UFCW LOCAL 1000 OKLAHOMA
HEALTH AND WELFARE PLAN "CARE-1000"
C/O NATIONAL EMPLOYEE BENEFITS ADMINISTRATORS, INC.
2010 N.W. 150TH AVENUE, STE 100 • PEMBROKE PINES, FL 33028
Toll Free Member Services: (866) 363-2733 • Fax: (954) 266-2079

Short Term Disability Benefit Application

Part A: To Be Completed by the Participant Claiming Benefit for Self					
1.	Employee Name		2.	SSN	- -
3.	Date of Birth		4.	Telephone Number	( ) -
5.	Address				
6.	Job Classification		7.	Hourly Rate of Pay	
8.	Is claim for a job related injury or illness?	YES / NO Please circle response	9.	Have you filed for Workmen's Compensation?	YES / NO Please circle response
10.	Please provide Name, Phone Number and Claim Number for any applicable Workers Compensation carrier				
11.	Is this claim the result of an accidental injury?	YES / NO Please circle response	**Note: If this disability is due to an accidental injury please complete and return the Fund's Accident/Injury Detail Form**		

The above answers are true and complete according to the best of my knowledge and belief. I authorize any employers, insurance company, dental / medical prepayment plan, employee welfare benefit (including the Trust), service organization, physician, practitioner or other person and hospital, including the Veteran's Administration or other Institution, to release or, obtain any medical / dental or benefit information that may be required to establish or support the validity of this claim, and further authorize said company, person or organization (including the Trust) in its discretion, to disclose to any other person, company organization so requesting any of my personal dental / medical or claim information obtained in any case study or claim review. A copy of this authorization shall be as valid as the original. I also acknowledge the subrogation right of the Plan and agree to repay any sums expended by the Plan for injury or sickness if I receive payment from another party or source. "See Summary Plan Description"

Employee Signature:_____ Date: _____

See reverse side for Parts B and C

Short Term Disability Benefit Application

Part B: Attending Physician's Statement					
1.	Patient Name		2.	Date of Birth	
3.	Patient Address				
4.	Date of Illness (First Symptom), Injury (Accident) or Pregnancy (LMP)		5.	Date of First Consultation for This Condition	
6.	Date Patient Able to Return to Work (Without Restrictions)		7.	Dates of Total Disability (Estimate if Necessary)	
8.	Name of Referring Physician		9.	Name and Location of Facility (if applicable)	
10	Diagnosis or Nature of Illness or Injury	1. 2.			
11.	Signature of Physician or Supplier	Signature:_____ Date: _____			
12.	Physician's Name, Address, Zip Code and Phone Number				

Part C: Employer					
1.	Employee Name		2.	Employee SSN	
3.	Hourly Rate		4.	Last Worked Date	
5.	Date Returned to Work (If Applicable)		6.	Termination Date (If Applicable)	
7.	Is the Disability Work Related?	YES / NO Please circle response	8.	If Yes to #7, has a Worker's Compensation Claim Been Filed?	YES / NO Please circle response
9.	Did Employee Use Vacation Time During Disability Period?	YES / NO Please circle response	10.	If Yes to #9, please provide Vacation dates.	
11.	Company Name, Address, Phone Number				
12	Please provide a breakdown of hours worked for the 8 weeks immediately preceding the month in which the employee's Short Term Disability began.				

Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8

1.	Signature of Employer Representative	Signature:_____ Date: _____