UFCWTRUST
Working For Your Benefit

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NORTHERN CALIFORNIA UFCW WHOLESALE HEALTH AND WELFARE TRUST FUND

DISABILITY WAIVER

If you have had twelve consecutive months of eligibility through Employer contributions and become disabled, the Trust will continue your eligibility and maintain benefits as they were immediately prior to the date of the disability.

During your disability, you must file a Disability Waiver claim with the Trust Fund Office before the end of each month in which you did not work at least 80 covered hours. Your eligibility will be provided on a month-to-month basis, subject to your filing of the required Disability Waiver form.

Coverage by Disability Waiver is provided on a lag month basis. The month of eligibility is the **second** month following the month of disability in which you did not work at least 80 hours.

The Trust Fund Office will notify you of the Plan's determination as to your eligibility for Disability Waiver within a reasonable period of time appropriate to your medical circumstances but in no case later than 45 days after receipt of the claim. The Board of Trustees may grant as to timeliness a waiver for substantial compelling reasons, which constitute good cause.

For ***non-work-related disabilities***, a maximum of six months of Disability Waiver coverage applies. After this six months of Disability Waiver coverage, you may make up to 18 self-payments under the Plan's COBRA provisions. Thereafter, you may qualify for up to six final Disability Waivers. The maximum period for all combined non-occupational disability periods is 30 months, i.e. the initial six month period, the 18 self-payments, and the six final waivers.

For ***work-related disabilities***, a maximum of twelve months of Disability Waiver coverage applies. After this twelve-month period, you may make up to 18 self-payments under the Plan's COBRA provisions. The maximum period is 30 months, i.e. the initial twelve-month period of Disability Waiver and the 18 self-payments.

If you have been granted the maximum Disability Waiver months noted above, you will not again be eligible for Disability Waiver until you have again worked 12 consecutive months for contributing Employers.

For a Retiree who was previously eligible for Disability Waiver as an Active Employee, up to a maximum of six Disability Waivers are provided if the Retiree is disabled, not yet age 65 and not yet eligible for Medicare.

NORTHERN CALIFORNIA UFCW WHOLESALE HEALTH PLAN

C/O UFCW & EMPLOYERS TRUST, LLC
P.O. BOX 4100 • CONCORD, CALIFORNIA 94524-4100 • TELEPHONE (800) 552-2400 • (925) 746-7549

DISABILITY WAIVER CLAIM

INSTRUCTIONS: 1. EMPLOYEE COMPLETE PART I OF THIS FORM. 2. ATTENDING PHYSICIAN COMPLETE PART II OF THIS FORM. 3. BE SURE THAT EVERY QUESTION IS PROPERLY ANSWERED. YOUR CLAIM CANNOT BE PROCESSED IF INCOMPLETE.

IMPORTANT: Your claim **MUST** be filed with the Fund Office ***in the month in which you were disabled*** and did not earn 80 hours in covered employment.

ELIGIBILITY: In order to qualify for Disability Waiver, an Employee must have had at least 12 consecutive months of Coverage by employer contributions or self payments immediately prior to the date of disability.

HOW TO FILE A CLAIM: Claim forms may be obtained from your Local Union Office, your Employer or the Fund Office. Please be sure to complete Part I of the claim form completely and carefully. Be sure your physician completes Part II of the form.

PART I — TO BE COMPLETED BY THE EMPLOYEE *(PLEASE PRINT)*

SOCIAL SECURITY NO. _____ LOCAL UNION NO. _____ TELEPHONE NUMBER _____

FIRST DAY OF DISABILITY NOT WORKED _____ DATE RETURNED (OR EXPECTED TO RETURN) TO WORK _____

EMPLOYEE'S NAME _____

STREET ADDRESS _____ CITY, STATE, ZIP _____

HEALTH PLAN — DISABILITY WAIVER SUMMARY — Refer to Plan Booklet for full rules and information.
Active employee eligibility may be continued in the event of a disability subject to the following: (a) An employee must have 12 consecutive months of eligibility either through employer contributions or self-payments. (b) **Disability waiver must be filed before the end of each month in which the Employee did not work 80 hours and is disabled.** Coverage and benefits will be provided on a month-to-month basis subject to submission of satisfactory evidence of disability for each month up to six months or 12 months for work-incurred injuries. (c) Disability waiver is provided on a lag month basis with the month of eligibility being the second month following the month of disability in which the member did not work 80 hours and was disabled. (**Note:** This is *not* a Pension Application. Contact the Pension Fund for Pension information.)

I ACKNOWLEDGE RESPONSIBILITY FOR THE PROPER AND TIMELY FILING OF THIS FORM. IF I DO NOT RECEIVE CONFIRMATION OF RECEIPT OF THIS FORM FROM THE ADMINISTRATOR **WITHIN 15 DAYS** OF THE DATE BELOW, I WILL CONTACT THE FUND OFFICE.

I authorize any medical information relating to this claim to be disclosed to and acquired by the Fund and such agents of the Administrator as are necessary to process this claim. Such information may be disclosed by a health care provider or other Plan Administrator, and will be used for the purpose of processing this claim. This authorization shall remain valid until the claim is paid, provided, such information shall be retained by the Fund if required by law.

Date Signed _____ Signature _____

PART II — TO BE COMPLETED BY THE DOCTOR *(PLEASE PRINT)*

This is to certify that the above-named was unable to work at his trade from _____ (YOU MUST STATE EXACT MONTH, DAY AND YEAR)
through _____ (MONTH, DAY AND YEAR) **because of disability.**

The following information is offered in support of this certification:

1. Nature of disability _____
2. Was this disability due to a previous illness or injury? Yes_____ No_____ **If injured on the job, show date** _____ (MO. DAY YEAR)
3. Date you first examined patient for above condition _____
4. Was patient confined to home or hospital due to disability? Yes _____ No _____
   If yes, indicate period of confinement here: From _____ To _____
5. Date of last treatment: _____
6. Is continuing treatment necessary? Yes _____ No _____ If continuing treatment is necessary, please request additional form(s).
7. Date patient returned to work _____ (OR DATE ANTICIPATED RETURN TO WORK)

Date _____ **Signature** _____ M.D.

Name *(Please Print)* _____ Telephone _____

Address _____

Notice to Physician: (1) The information requested on this form is used to determine health coverage to your patient. (2) Health coverage may be denied if information is incomplete or not timely filed in the month of disability.

PART III — TO BE COMPLETED BY THE ADMINISTRATIVE OFFICE *(Do Not Write in this Space)*

H & W Cov.Mo.	Work Mo.	Hours	Date Processed	Initials	H & W Cov.Mo.	Work Mo.	Hours	Date Processed	Initials
☐ 7/20					☐ 1/20				
☐ 8/20					☐ 2/20				
☐ 9/20					☐ 3/20				
☐ 10/20					☐ 4/20				
☐ 11/20					☐ 5/20				
☐ 12/20					☐ 6/20				
		TOTAL					TOTAL		

NOT ELIGIBLE DUE TO _____

Date _____ Administration Signature _____