LOCAL UNION NO. 569
INTERNATIONAL
BROTHERHOOD OF
ELECTRICAL
WORKERS

SAN DIEGO
ELECTRICAL HEALTH & WELFARE TRUST
P.O. BOX 231219
SAN DIEGO, CALIFORNIA 92193-1219
(858) 569-6322
(800) 632-2569
DeFrance Printing Co.
VISIT www.569trusts.org

SAN DIEGO COUNTY CHAPTER
NATIONAL
ELECTRICAL
CONTRACTORS
ASSOCIATION INC.

EMPLOYEE DISABILITY CREDIT ACKNOWLEDGMENT

Due to accident or illness I, _____ (Employee's name), have become Disabled. I hereby acknowledge that as of the onset of my Disability I was Covered in Plan A or Plan B of the San Diego Electrical Health & Welfare Plan and I have been continuously covered in Plan A and/or Plan B for at least the twelve (12) consecutive months immediately preceding the onset of my Disability to qualify for Disability Credit.

I understand that if I am unable to work for at least 30 consecutive calendar days it is possible I may qualify for "Disability Credit" in order to maintain continuous coverage until I am released by my Physician to return to any form of work and that once the initial 30-day period of disability is satisfied a month of proven Disability shall be any calendar month during which I was unable to work due to this Disability for at least 20 calendar days.

I understand that I may only qualify to receive up to a maximum of 12 months of Disability Credit, regardless of the number of periods of Disability that may occur unless I have been covered in Plan A and/or Plan B for at least 12 consecutive months following the prior exhaustion of the maximum number of allowable Disability Credits.

I understand that each month of continuos coverage maintained by Disability Credit shall be considered one month of COBRA coverage and be applicable to the maximum period of COBRA coverage to which I am entitled to.

In the event I am receiving Disability Credit and I return to any occupation for wages either on a "modified duty" status or a "full time" status **or** profit for other than a signatory employer I recognize that I will no longer receive Disability Credit and any previously frozen Reserve Account hours will be immediately forfeited. I understand my coverage will be terminated as of the first day of the month following the month in which I engaged in such employment even if previously earned Disability Credit would have continued my coverage for that month or thereafter.

I hereby agree that it is my responsibility to inform the Trust Office of my return to any form of employment including, but not limited to, the electrical construction trade. In the event my coverage is terminated as a result of my having returned to work during any period of coverage relating to Disability Credit, if it is ultimately determined that any amount benefits, premiums and/or service fees incurred on or after the date my coverage was terminated were paid on behalf of myself or any dependent(s) I acknowledge that it will be my responsibility to make full restitution to the Trust.

_____ _____

Participant's Signature Date

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PHYSICIAN'S DISABILITY CERTIFICATION

Name of Patient:_____ DOB: _____

Address: _____

Patient Soc. Sec. #: (xxx-xx-_____) Phone number: _____

Diagnosis: _____
_____
_____

Is the patient able to perform Electrical work? ☐ Yes ☐ No

If "No", what is the first date the patient was unable to work?_____

How often will the patient be re-evaluated? _____

At this point in time when do you feel the patient may be able to return to work in the electrical construction trade? _____

_____ _____
Physician's Name (Please print or type) Phone Number

_____ _____
Physician's Signature Date

Please fax this form and chart notes/records to (858) 565-2951.