Plumbers Local Union No.1

Welfare Fund Extended Benefit Statement

50-02 5th Street, Long Island City, New York 11101

Tel. (718) 835-2700

(U) www.ualocal1funds.org

Date Complete FOR OFFICE USE ONLY

Note: An Extended Benefit Statement must be returned to the Fund Office by the 20th of each

month following the month for which the statement is given.

Application for Benefit Form

MONTH

(A) Member Information		Use a ba	allpoint pen to	complete form
			•	•
(1) Social Security Number (2) Last	(3) First			(4) Init.
(5) Street	(6) City	(7) State	(8) Zip	· · · · · · · · · · · · · · · · · · ·
BTJ BT MESJ MESH OTJ OTH				
(9) Date of Birth (10) Classification (Circle One)	(11) Phone Nur	mber		
(12) E-mail Address				
			$H \perp$	
(13) Use Form W4 Option (14) Last Employer	(1	5) Last date of Emplo	yment	
This benefit is available during periods for which the Union certifies there is unemployment in the jurisdi unemployment, you may apply for an Unemployment Extension within one year from the date your eligibilit continue to be eligible under this Plan for up to six (6) months of coverage at no cost from the date your emonthly rate to be determined by the Trustees annually. However, the total extension cannot exceed 50% of the length of the period during which you were unemployment. If you reject COBRA and elect the Unemployment Extension, an additional 18-month exter The cost for the additional 18-month extension will be at a monthly rate to be determined by the Trustee Unemployment Extension. (C) Unemployment Certification (Must be signed by Member) Welfare Fund, Extension of eligibility for the month of I attest that I am not employed with any Contributing Employer, with any Employer, Self-Employed in the same or related business as a Contributing under the jurisdiction of the Union. I have no other primary health insurance at week under the applicable Collective Bargaining Agreement. I understand that coverage to me and any dependents. Signed under penalty of perjury	y would otherwise terming in the ingibility would otherwise eligible for benefits from the ingibility would be included by the ingibility of the ingibility	nate. Generally, under the terminate, plus an addition this Plan, measured the Unemployment Extend COBRA Continuation (Cobron State of Cobron	tional six (6) month id immediately pre- sion of up to 12 m Coverage, you are business as red in any bus ork normal wor	Extension, you may as of coverage at a ceeding the date of contribs is exhausted. Not eligible for the contributing iness which is king hours per
(ORIGINAL SIGNATURE OF APPLICANT) (D	ATE)			
(D) Unemployment Certification (Must be signed by Local 1)				
□ (D) PLUMBERS LOCAL UNION NO. 1 UNEMPLOYM	MENT CERTIF	FICATION		
For the Month(s) being claimed is/was listed on Plumbers Local Union No. 1 L	Inemployed Memb	ers List.		
(ORIGINAL SIGNATURE OF LOCAL 1 REPRESENTATIVE) (D	ATE)			
		FOR OFFICE USE ONLY		
		PERIOD END DATE		
INSTRUCTIONS: For Benefits, fill out this form and sign it. Also, Section "D" will need to		GROSS AMOUNT		
Local 1. Please submit completed form to: Plumbers Local Union No.1 Welfare Fund 5 Long Island City, New York 11101. For questions: please call the Fund Office Welfare (719) 825 2700 expirit our web site at year years of the control of the contro		PYMTS.	TYPE	