Extended Benefit Statement (D)

Welfare Fund **4/2020**

PLUMBERS LOCAL UNION No.1
WELFARE FUND

50-02 5th Street, Long Island City, New York 11101
Tel. (718) 835-2700 Fax (718) 641-8155

(A) Member Information *Use a ballpoint pen to complete form*

(1) Social Security Number _____ (2) Last _____ (3) First _____ (4) Init.

(5) Street _____ (6) City _____ (7) State _____ (8) Zip _____

(9) Date of Birth _____ (10) Sex M F (11) Home Phone Number / Cell Number _____

(12) E-mail Address _____

(13) Retired (14) Active (15) Current or Last Employer _____ (16) Last date of Employment _____

(B) Extension of Eligibility during Periods of Disability:

An eligible Employee whose eligibility terminates under the rules of this Plan because of Temporary Disability may apply for a Temporary Disability Extension. The Employee must submit a request in writing and present evidence that the member is or has become disabled during the eligibility period. If eligibility is extended, the member must provide a notarized statement each month that he or she is not working and is Temporarily Disabled. The Trustees may terminate the Employee's Temporary Disability Extension if the member fails to submit the monthly-notarized statement or the member is classified as totally disabled. (See SPD for additional requirements).

(C) Member Certification

Monthly Disability / Workers' Compensation Certification

Welfare Fund, Extension of eligibility for the month of _____ 20 _____.

I attest that I am Temporarily Disabled under State Disability Benefits and/or a Workers' Compensation claim. I understand that the Welfare Fund is relying on this certification to provide health coverage to me and any dependents. I agree to notify the Plumbers Local Union No. 1 Welfare Fund if I return to any employment and/or if I become eligible for a Social Security Award and/or Medicare. I understand that the Welfare Fund is relying on this certification to provide health coverage to me and any dependents.

Signed under penalty of perjury

_____ _____
(ORIGINAL SIGNATURE OF MEMBER) (DATE)

OR notarized below:

Sworn to before me this
_____ Day of _____, 20_____

_____
(SIGNATURE OF NOTARY PUBLIC)

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.

Fund Office Use Only Date Received: _____ Date Entered: _____ Entered By: _____

Type of coverage: _____

NOTE: PLEASE MAKE A COPY OF THE FORM FOR YOUR PERSONAL RECORDS. **PIB.WFDEF.4.2020**