

Extended Benefit

Return to Work Statement (RW)

Welfare Fund

06/220

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(1) Social Security Number	(2) Last	(3) First	(4) Init.		
(5) Street		(6) City	(7) State	(8) Zip	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(9) Date of Birth	(10) Gender	M	F	(11) Home Phone Number / Cell Number	
(12) E-mail Address			<input type="text"/>		
<input type="checkbox"/>	<input type="checkbox"/>	(15) Current Employer		(16) Return to Employment Date	
(13) Retired	(14) Active				

(B) Return to work following Extension of Eligibility During Periods of Unemployment, Disability or Workers' Compensation:

See pages 4-8 of the SPD for complete description and examples of benefit.

(C) Member Certification

Monthly Unemployment/Disability/Workers' Compensation Certification

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

I attest that as of _____, 20___ I have returned to covered Employment for the above listed Employer and I am working the normal hours per week under the applicable Collective Bargaining Agreement. 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 Welfare Fund if I again become unemployed, collecting or unable to collect unemployment benefits, and/or again become disabled. The facts herein stated are true and correct in every respect and are made for the purpose of enabling the Welfare Fund to extend coverage for the undersigned in accordance with the rules of the Plan. Signed under penalty of perjury,

(ORIGINAL SIGNATURE OF MEMBER)

(DATE)

Note: An Extended Benefit Notarized Statement must be returned to the Fund Office by the 20th of each month following the month for which the notarized statement is given.

Fund Office Use Only

Date Received: _____ Date Entered: _____ Entered By: _____

Type of coverage: _____