SOCIAL SERVICE EMPLOYEES UNION LOCAL 371

Welfare Fund

1501 BROADWAY, SUITE 450. • NEW YORK, N.Y. 10036 • (212) 777 - 9000
FAX : (212) 673 – 3813

Dear Member,

Enclosed please find the requested Disability Form as well as the Disability Agreement Form, both must be signed and dated in order for your claim to be processed. The Disability Agreement form explains that you agree to ***repay the Welfare Fund for any funds received from Workers Compensation, dedicated sick time, 3.5 grants or any other awards***. Being on payroll makes you ineligible to receive the Disability benefit.

To be eligible you must be meet the following criteria:

- Be under the care of a Physician
- Member must be on an approved leave (FMLA, Maternity or Medical)
- Member is no longer on payroll (exhausted all sick, Annual and comp time)
- Medical information is sufficient
- Member must be out 7 consecutive days
- Claims must be submitted within 60 days of exhaustion of time
- Disability form signed and dated by physician and member
- We do not accept fax copies
- ***Every 4 weeks an updated supplemental form is required from your doctor***
- ***If the leave is extended you must provide a Leave Extension letter from personnel***
- If your physician extends your return to work date we must have it in writing

It takes approximately 2 to 3 weeks to process a claim. ***You must notify this office when you return to work. Please provide a copy of your reinstatement letter from personnel once you return to work.*** Please feel free to contact us at (212) 777-9000 ext. 3090 or 3033 or email us at **dbl@sseu371funds.org** if you have any questions.

DISABILITY AGREEMENT FORM

I understand that in order to be eligible for Disability Benefits I must:

1. Complete the initial and periodic Disability claim form

2. Agree to notify the Disability claims department of the receipt of any award that will keep me on payroll (i.e. 3.5 grant, dedicated sick leave etc.). Notify the Disability Claims department of any plans for Disability Retirement or salary Settlement from Worker's Compensation.

3. Agree to repay the Disability Fund for any period in which Disability payments were made while at the same time I received full or partial salary from my agency from Worker's Compensation or Retirement Disability.

I have read and understand the conditions for receiving Disability benefits.

Signature_____

Date_____

Dear Sir/Madam:

Please return all documents **(at the same time to avoid delays)** to the email address **dbl@sseu371funds.org.**
Documents required are:

1. Completed, signed and dated Disability application (bottom portion must be completed and signed by your medical doctor)
2. Signed and dated Agreement form
3. Leave Approval letter from your Agency personnel office stating your last day worked and last day paid

If applicable:

4. Workman's comp letter and/or Grant letter
5. Paid Family Leave award letter

DISABILITY
CLAIM FORM

SOCIAL SERVICE EMPLOYEES UNION LOCAL 371 WELFARE FUND

1501 BROADWAY, 4TH FLOOR ♦ NEW YORK, NEW YORK 10036 (212) 777-9000

THIS SPACE FOR OFFICE USE ONLY	ACCT. NO.	INDV. CODE	CLAIM DATE	RJ

MEMBER LAST NAME	MEMBER FIRST NAME	SEX ☐ F ☐ M	MEMBER TITLE CODE For Office Use Only	Annual Salary	Date of Birth

HOME ADDRESS
NUMBER STREET CITY STATE ZIP APT. NO

MEMBER MAIDEN NAME

PAYROLL TITLE	DEPARTMENT	WORK LOCATION	TIMEKEEPER PHONE

DISCRIBE DISABILITY

MEMBER SOCIAL SECURITY NO.

HOME PHONE

DATE YOU BECOME DISABLED LAST DAY WORKED

HAVE YOU APPLIED FOR WORKER'S COMPENSATION? YES ☐ NO ☐

AFFIDAVIT

I am applying for Social Service Employees Union Local 371 Welfare Fund disability benefits and declare that all the Claimant's Information submitted above is complete and to the best of my knowledge is true.

MEMBER'S SIGNATURE

MEMBER'S HEALTH PLAN COVERAGE (CHECK ONE) ☐ GHI-CBP ☐ HIP-HMO ☐ MED-PLAN ☐ OTHER

PYYSICIAN'S STATEMENT
PATIENT'S SYMPTOMS (SUBJECTIVE)

OBJECTIVE FINDINGS

LABORATORY TESTS AND /OR X-RAYS PERFORMED AND RESULTS

DIAGNOSIS

IF SURGERY IS INDICATED, PLEASE ENTER TYPE AND DATE

NAME OF HOSPITAL AND DATES OF CONFINEMENT

IF PREGNANCY RELATED, PLEASE ENTER DATE(S) EDC DOB

ENTER DATES FOR THE FELLOWING ♦

DATE FIRST TREATMENT FOR THIS DISABILITY	DATE MOST RECENT TREATMENT FOR THIS DISABILITY	DATE UNABLE TO WORK BECAUSE OF THIS DISABILITY	DATE ABLE TO RETURN TO WORK

PHYSICIAN'S NAME: OFFICE PHONE

OFFICE ADDRESS
STREET AND NUMBER CITY STATE ZIP

REGISTRY NO.	PHYSICIAN'S SIGNATURE	DATE

PLEASE RECORD ANY OTHER INFORMATION WHICH HAVE A BEARING ON THIS PERSON'S DISABILITY: