

# 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](mailto:dbl@sseu371funds.org)** if you have any questions.

#### TRUSTEES

Akm Amran  
Mark Casner  
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Jose Negron  
Michelle D. Woody

Administrator  
Denise L. Barr

Associate  
Administrator  
Iris B. Clark

Controller  
Christopher Leavey

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/HR office stating your last day worked, last day paid and anticipated return to work date

**If applicable:**

4. Worker's compensation letter and/or Grant letter
5. Paid Family leave award letter



## 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 \_\_\_\_\_