Sick Leave / Disability Extension Form Checklist:

Follow these steps to ensure your form is complete and your claim can be processed quickly

Part 1 - EMPLOYEE SECTION (TO BE FILLED OUT BY EMPLOYEE ONLY)

1-A Employee Personal Contact Information

- ☐ Check **one** box at the top of the form
- ☐ This form should be completed once you have returned to work, or at the end of your first full work week out, whichever occurs sooner. Note: Notify the TFO if you return earlier than the Physician's estimated return date.
- ☐ If you are absent more than seven (7) calendar days, you must file for State Disability Insurance (SDI), and SDI Computation Form must be submitted. Note: California Paid Family Leave (PFL) is not acceptable.
- ☐ Ensure all fields are completely filled out and legible
- ☐ For Disability Extension: Form must be received 60 days from the date your coverage ended or you received the COBRA continuation notice
- ☐ If **new address**, ensure to check **"Yes"** under "Is this an Address Change"

1-B Dates of Illness, Injury, or Disability / Store Information

- ☐ Last Day Worked and First Date Absent **must** match the same information in Employer's Section 2-A
- ☐ This form should not be completed and turned in prior to first date of the Illness, Injury, or Disability
- ☐ If you have returned to work, include the Return-To-Work Date.

1-C Illness, Injury, or Disability Information

- ☐ Illness, Injury, or Disability must be **your own**; confirm by checking **"Yes"**
- ☐ If this Illness, Injury, or Disability is related to another Sick Leave Claim within 60 calendar days, check **"Yes"**
- ☐ If you were injured on the job, check **"Yes"** and include the date of injury and any Workers' Compensation information (adjuster's name, computation form, check stubs, etc.)
- ☐ If you saw a Physician, Part 3 Physician's Statement must be completed by the Physician or attach your "Doctor's Note" for any disabilities greater than 7 days, or to cover the First Day Absent

1-D Employee Signature (form must be signed and dated)

- ☐ For Disability Extension and Sick Leave, **you must sign and date**

Part 2 - EMPLOYER SECTION (TO BE FILLED OUT BY EMPLOYER ONLY)

2-A Schedule and Pay Information

- ☐ Check the correct box for either a **Sun-Sat** or a **Mon-Sun** schedule
- ☐ Ensure the dates for the schedule **match** the days of the week above for Sun-Sat or Mon-Sun
- ☐ First Week Schedule must reflect the Employee's **complete** regular schedule (e.g. if Employee is normally scheduled for 40 hours per week, this schedule should reflect 40 hours on the Employee's normal days, and should not be modified for a scheduled appointment or procedure)
- ☐ The First Date Absent must fall **within** the First Week Schedule; the calendar day, the dates, and hours must match (this schedule will be used for the duration of this claim)
- ☐ After Employee has returned to work, fill out "Date Employee Returned to Work" and Return-to-Work Schedule

2-B Employer's Signature (form must be signed and dated)

- ☐ **Employer must sign and date** on or after Employee's First Date Absent or after Employee returns to work

Part 3 - PHYSICIAN'S STATEMENT (TO BE FILLED OUT BY PHYSICIAN ONLY)

3-A Illness, Injury, or Disability Certification

- ☐ Ensure all fields and hospitalization check box are filled out as it pertains to this Illness, Injury, or Disability

3-B Physician's Information (form must be signed and dated)

- ☐ Physician must sign and date **on or after the date the Employee was seen for an appointment**

Sick Leave Claim Form/Disability Extension Application

(Select Plans administered by UFCW & Employers Trust, LLC)

ADDITIONAL IMPORTANT INFORMATION

For UEBT and UCBT Plans

IF YOUR ABSENCE LASTS LONGER THAN 7 CALENDAR DAYS, YOU MUST FILE FOR STATE DISABILITY INSURANCE (SDI)

(1) Ill, Injured, or Disabled more than Seven Calendar Days (Three Calendar Days If Disability Caused by Work) from first day of Absence* - Sick Leave Benefits do not duplicate benefits payable by Workers' Compensation (WC) or State Disability Insurance (SDI). In order to receive your maximum benefits, you MUST file for SDI or WC and attach one of the following:

- A copy of your SDI Notice of Computation; or
- A Workers' Compensation Benefit Notice

If the Trust Fund receives this form without your SDI statement and the illness, injury, or disability is greater than seven days, the Trust Fund will reduce your Sick Leave benefits by the maximum State Disability benefit. You MUST submit a copy of your first SDI or WC benefit notice to the Trust Fund in order to be paid for any additional benefits that are due. Call the SDI office at (800) 480-3287 for information on SDI filing deadlines. You will be requested to return any overpayments.

You cannot receive more than 100% of your regularly scheduled wages. When integrating with SDI and WC, SDI and WC pay first toward your regularly scheduled wages. The Trust Fund will pay the difference between your regularly scheduled wages and what SDI or WC pays, as long as you have available Sick Leave hours.

**For example: If you are first absent on a Monday due to an illness, injury, or disability and you are still absent the following Monday (more than 7 calendar days), then SDI becomes your primary payer of lost wages. You MUST file for SDI in order to receive your entire Sick Leave Benefit amount, because your illness, injury, or disability lasted longer than 7 calendar days.*

(2) Timely Filing Limit - You will be disqualified for the Sick Leave Benefit and/or Disability Extension if you do not file your application by the following deadlines:

- *Disability Extensions:* 60 days from the date you receive your COBRA/Loss of Eligibility notification
- *Sick Leave:* One year from the first day of your disability

(3) Eligibility For Disability Extensions - Requirements include the following:

- Your disability must begin during a month in which you are eligible for benefits. Standard Plan participants must also have been eligible for at least twelve (12) months prior to the work month in which you became disabled.
- Your total Qualifying Hours can be a combination of hours not worked due to disability and hours worked. The hours you are unable to work because of your disability plus the hours you actually worked, if any, must equal or exceed the minimum monthly Qualifying Hours in order to maintain eligibility.
- If your disability lasts more than seven calendar days, you must submit proof of your disability. You can request your doctor complete Part 3 of this form or you may attach the notifications you received from State Disability or Workers' Compensation for benefits paid to you for the calendar month(s) for which this extension application is made.
- If your Disability Extension Application is granted but you remain disabled when your extension expires, and you are eligible for additional extensions (please confirm with Member Services if unsure of your eligibility), you must file a new application within 60 days from the date the last Disability Extension expired.

You will receive notification from the Trust Fund Office when your application is processed. For additional information about Disability Extensions and the maximum number allowed, please refer to you Summary Plan Description.

PLEASE MAIL COMPLETED FORMS TO:

Sick Leave Claims
P.O. Box 4100
Concord, CA 94524-4100
Fax: (925) 746-7549
Please call Member Services if you have any questions: (800) 552-2400

Sick Leave Claim Form/Disability Extension Application

(For use in all Plans administered by UFCW & Employers Trust, LLC)

CHECK ONE: ☐ **Sick Leave Only** ☐ **Disability Extension ONLY** ☐ **Sick Leave AND Disability Extension**

Part 1 EMPLOYEE SECTION (TO BE FILLED OUT BY EMPLOYEE ONLY)

Part 1 must be completed by the Employee prior to the Employer completing Part 2

Employee Personal Contact Information: *The contact information you provide UFCW & Employers Trust, LLC, on this form will be shared with the benefit funds in which you participate and which are administered by UFCW & Employers Trust, LLC, in order to ensure communications for all Funds continue to reach you.*

1-A

Last Name	First Name	Middle Initial	Date of Birth	Member ID or Last 4 SSN	Home Phone#

Mailing Address	City	State	Zip Code	Cell Phone#

Is this an Address Change? ☐ NO ☐ YES Effective Date of Address Change (MM/DD/YYYY): _____

Dates of Illness, Injury, or Disability/ Store Information

1-B

Last Day Worked Prior to your own Illness, Injury, or Disability (MM/DD/YYYY)	First Date Absent Due to your own Illness, Injury, or Disability (MM/DD/YYYY)	Return-to-Work Date (MM/DD/YYYY)

Store Name	Store City/State	Store Phone#

Illness, Injury, or Disability Information (answer all questions): *For Disability greater than 7 calendar days, SDI Computation Form is required. If Disability is a work related injury and greater than 3 calendar days, then Workers' Compensation Computation Form is required.*

1-C

Did you see a doctor during your Illness, Injury, or Disability? ☐ NO ☐ YES

Is this Illness, Injury, or Disability related to the same Illness, Injury, or Disability you have claimed within the last 60 calendar days (for SDI integration)? ☐ NO ☐ YES

IF YES: _____ DATES OF PREVIOUS CLAIM (MM/DD/YYYY-MM/DD/YYYY)

Is this for your own Illness, Injury, or Disability? ☐ NO ☐ YES

Were you injured on the job? NO ☐ YES ☐

IF YES: _____ DATE OF INJURY (MM/DD/YYYY)

Employee Signature (form must be signed and dated)

1-D

By signing below, I certify that I am requesting Sick Leave payments or Disability Extensions for the days of employment lost because of my own illness, injury, or disability, and not the illness, injury, or disability of a family member. I understand that I may be subject to civil and/or criminal penalties for committing a fraudulent insurance act if I knowingly provide any materially false information to, or conceal any material facts from, the Trust Fund with the intent to defraud or mislead the Trust Fund to obtain Disability Extensions. If you file a fraudulent Sick Leave claim, a penalty may be charged against your account amounting to twice the number of fraudulent hours you claimed. You also may be subject to a fine or confinement in a state prison.

EMPLOYEE'S Signature	**Date Signed:**
X	_____ MM/DD/YYYY

Continue on Page 2

Continued from Page 1

UFCW TRUST
Working For Your Benefit

Sick Leave Claim Form/Disability Extension Application

(For use in all Plans administered by UFCW & Employers Trust, LLC)

Employee Last Name	Employee First Name	Member ID or Last 4 SSN (from Page 1)

Part 2 EMPLOYER SECTION (TO BE FILLED OUT BY EMPLOYER ONLY)

This section must be completed by your Employer. Your Employer may require that only certain authorized signatures be accepted. Please be sure to obtain the proper Authorized Signature. The Employer should indicate the schedule you would have worked had you not been absent due to your Illness, Injury, or Disability.

2-A

Regularly Scheduled Work Hours Per Week: _____ Hours Per Week

Hourly Rate: _____ Pay Rate

Check one: ☐ Full-Time ☐ Part-Time

Did Employee work or return to work anytime during this Illness, Injury, or Disability? ☐ NO ☐ YES

IF YES: HOURS _____ DATE(S) PAID _____

Did Employee receive any wages since the last day worked (e.g. holiday, vacation, funeral, birthday, etc.) during this Disability? ☐ NO ☐ YES

IF YES: HOURS _____ DATE(S) PAID _____

Was employee injured on the job? ☐ NO ☐ YES

IF YES: DATE OF INJURY (MM/DD/YYYY) _____

Was employee on the night crew during this Disability? ☐ NO ☐ YES

IF YES: # OF MISSED SHIFTS _____

Last Day Employee Worked Prior to Disability (MM/DD/YYYY)

Date Employee Returned to Work (MM/DD/YYYY)

First Date Absent Due to Disability (MM/DD/YYYY)

FIRST WEEK SCHEDULE: ***Full Schedule for 1st Week in which Disability Begins.*** *Specify the number of hours employee* ***would have been scheduled*** *to work each day during the first week of the Disability.* ***Check one box for weekly schedule.***

☐ **Sun-Sat** Sun Mon Tue Wed Thu Fri Sat
☐ **Mon-Sun** Mon Tue Wed Thu Fri Sat Sun

Dates (MM/DD)							
# Hours Scheduled							

RETURN-TO-WORK SCHEDULE: ***Completed ONLY it employee has returned to work.*** *List the Employee's Return Schedule (include dates they would have worked if they were not out on Disability).* ***Check one box for weekly schedule.***

☐ **Sun-Sat** Sun Mon Tue Wed Thu Fri Sat
☐ **Mon-Sun** Mon Tue Wed Thu Fri Sat Sun

Dates (MM/DD)							
# Hours Scheduled							

Employer's Signature (form must be signed and dated) *This form should not be completed prior to first date of the Illness, Injury, or Disability.*

2-B

I, the undersigned, verify that the statements contained herein above under the heading "Employer Section" are true and correct and I understand that these statements will be presented to the Trustees of the Trust Fund used in support of the above named Employee's Sick Leave Claim. *I understand that any false or fraudulent statement made herein may subject me to penalties as prescribed by law.*

Authorized EMPLOYER'S Name (Print) **Title:** **Employer's Phone#**

Authorized **EMPLOYER'S** Signature X

Date Signed: _____ MM/DD/YYYY

Part 3 ATTENDING PHYSICIAN'S STATEMENT (TO BE FILLED OUT BY PHYSICIAN ONLY)

UEBT/UCBT Members: *In order to be paid for the first day of your illness, injury, or disability or to be paid beyond the first week of disability, this section must be completed by your doctor. You MUST be seen by your doctor during your disability to be paid for the first day* ***(does not apply to UCBT Save Mart Office and Yosemite Wholesale Members)****. Please be sure your doctor provides the date you were treated. Telephone advice does NOT satisfy this requirement. A disability day is defined as any day in which you do not work more than 50% of your scheduled shift. If you work more than 50% of your scheduled shift, this day will not be considered as a disability day and therefore will not be considered as your deductible day when not seen by a physician. (****Valley Drug Members:*** *To be eligible for the first day, in this case you must also have 180 hours in your sick leave bank on the last day of the month preceding your disability, unless you are hospitalized or had surgery.)*

3-A

Patient Name: _____ (Last First Middle Initial) Date of Birth: _____ MM/DD/YYYY

Patient has been continuously disabled (unable to work due to his/her own illness or injury) from: _____ MM/DD/YYYY through _____ MM/DD/YYYY

If patient is still disabled, give estimated date patient will be able to return to work: _____ MM/DD/YYYY

Date(s) seen by doctor: _____

Was patient hospitalized? ☐ NO ☐ YES Hospital: _____ (Name City State) Confined From: _____ MM/DD/YYYY to: _____ MM/DD/YYYY

3-B

Attending Physician: _____ (Last Name First Name Degree)

Address: _____ (Street Address City State Zip) Phone: _____

Attending Physician Signature: X _____ Date Signed: _____

IF YOUR ABSENCE LASTS LONGER THAN 7 CALENDAR DAYS, YOU MUST FILE FOR STATE DISABILITY INSURANCE (SDI)