Disability Extension Form Checklist:

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

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

1-A Employee Personal Contact Information

☐ Ensure all fields are completely filled out and legible
☐ 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" and date the change

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

☐ 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 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

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

☐ For Disability Extension, **you must sign and date**

Part 2 - PHYSICIAN'S STATEMENT (TO BE FILLED OUT BY PHYSICIAN ONLY)

2-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

2-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**

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Disability Extension Application
(For PACT Plan)

ADDITIONAL IMPORTANT INFORMATION
For PACT Plan

(1) Timely Filing Limit - You will be disqualified for the 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

(2) 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 2 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 your Summary Plan Description.

PLEASE MAIL COMPLETED FORMS TO:

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

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

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):

1-C	Did you see a doctor during your Illness, Injury, or Disability? ☐ NO ☐ YES
	Is this for your own Illness, Injury, or Disability? ☐ NO ☐ YES

Employee Signature (form must be signed and dated)

1-D	By signing below, I certify that I am requesting 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.	
	EMPLOYEE'S Signature **X**	**Date Signed:** _____ (MM/DD/YYYY)

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

Part 2 ATTENDING PHYSICIAN'S STATEMENT (TO BE FILLED OUT BY PHYSICIAN ONLY)

2-A

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

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

2-B

Attending Physician:_____
Last Name First Name Degree

Address: _____ Phone: _____
Street Address City State Zip

Attending Physician Signature: **X**_____ Date Signed: _____