RETURN THIS FORM TO:

BAY AREA DELIVERY DRIVERS SECURITY FUND
4160 DUBLIN BLVD., SUITE 400 ♦ DUBLIN, CA 94568-7756
(Phone) 800-654-1824 (Fax) 925-833-7301

SHORT-TERM DISABILITY INCOME COVERAGE AND/OR CONTINUATION OF HEALTH PLAN IF TOTALLY DISABLED*

PART A — TO BE COMPLETED BY EMPLOYEE

☐ Male ☐ Female

Please print last name First Middle

Home address

City-State-Zip Code Home phone number

Date of birth Social Security Number – or – Plan ID#

Name of Employer (firm name)

Occupation Local Union Number

First date you were unable to work at time (am-pm) Employer's Phone #

Is this disability due to occupational cause or causes? ☐ No ☐ Yes
Has a claim been filed for worker's compensation? ☐ No ☐ Yes
Will such a claim be filed? ☐ No ☐ Yes

I agree that all answers in this section are true and correct to the best of my knowledge.

Employee's Signature Date Signed

DESCRIBE DISABILITY:

WAS YOUR DISABILITY DUE TO AN ACCIDENT?
(If so, complete below)

Date of Accident: Hour:

Where did Accident occur?

Disability Income coverage not available for work-incurred injury/sickness
Maximum continuation of coverage is 6 months (see page 11 of your Summary Plan Description for details)

The attending physician must complete the information below. Patient must sign authorization to release information on reverse side of this form.

NOTICE: It is illegal to file a false or fraudulent claim or to knowingly help someone else file one. You may be fined or sent to prison for doing so. You may also be required to pay civil damages.

PART B — ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis and concurrent conditions (If diagnosis code other than ICDA* used, give name.)

2. Is condition due to injury or sickness arising out of patient's employment?
No ☐ Yes ☐

3. Dates of services *(if previous form submitted to this carrier, you need show only dates since last report.)*

4. Date symptoms first appeared or accident happened.

5. Date patient first consulted you for this condition.

6. Patient ever had same or similar condition? No ☐ Yes ☐
(If yes, state when and describe.)

7. Patient still under your care for this condition?
No ☐ Yes ☐

8. **Patient was continuously totally disabled (unable to work)**
FROM THROUGH

9. Patient was partially disabled
FROM THROUGH

10. **If still disabled, date patient should be able to return to work.**

11. Patient was house confined
FROM THROUGH

12. Hospitalization dates
ADMITTED DISCHARGED

13. Does patient have other health coverage? No ☐ Yes ☐
(If "Yes" identify)

Date Physician's Name *(Print)* Signature Degree Telephone Tax ID No.
( )

Street Address City or Town State Zip Code

*ICDA – International Classification of Diseases

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PART C **TO BE COMPLETED BY EMPLOYEE**

AUTHORIZATION FOR RELEASE OF INFORMATION
GROUP HEALTH BENEFITS

I AUTHORIZE any physician, medical practitioner, hospital, Veterans Administration Hospital, clinic, other medical or medically related facility, insurance company, consumer reporting agency, employer or group policy holder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me and any other non-medical information of me to give to Bay Area Delivery Drivers Security Fund (hereinafter called The Fund) or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by The Fund or its authorized claims paying administrator to determine eligibility for benefits or services under a policy. Any information obtained will not be released by The Fund to any person or organization EXCEPT to reinsuring companies, group policy holder, contract holder, or other persons or organizations performing business or legal services in connection with my claim or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of the Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two and one-half years from the date shown below.

Insured's Signature

X _____ **Date** _____

IMPORTANT

THE ADMINISTRATIVE OFFICE DOES NOT GIVE THIS INFORMATION TO YOUR EMPLOYER. IT IS YOUR RESPONSIBILITY TO FURNISH YOUR EMPLOYER WITH DOCUMENTATION OF YOUR DISABILITY.