SANTA MONICA UNITE HERE
HEALTH BENEFIT AND RETIREMENT TRUST FUNDS

Administered By: Benefit Programs Administration
Telephone • (866) 345-5189 • (562) 463-5075 • FAX (562) 463-5894

EMPLOYEE DISABILITY CREDIT FORM

If you (Patient) will be unable to return to work immediately as a result of a current or recent disability, this form must be completed by the attending physician and returned.

ELIGIBILITY FOR BENEFITS WILL TERMINATE IF WE DO NOT RECEIVE THIS INFORMATION.

This form must be completed in full.

Name of Patient _____ Date _____

Social Security No. _____

Address _____

_____

Phone Number _____

Current or Last Employer _____

Nature of Disability _____

_____

Date Patient First Unable to Work _____ Date Patient May Return to Work _____

Physician's Signature and Medical Degree _____

Physician's Address _____

_____

Phone Number _____

BELOW THIS LINE RESERVED FOR USE BY HEALTH BENEFIT FUND

Credit For _____