

**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 _____