United Employees Benefit Trust
Non-Profit Provider of Employee Benefits Since 1965

220 S 27th St, Suite B * Tacoma WA 98402
(253) 474-1214 or (800) 223-2449
Facsimile: (253) 474-7180

TIME LOSS CLAIM APPLICATION

EMPLOYEE – COMPLETE THIS SECTION

1. Name: _____ 2. SSN or UID #: _____
3. Mailing Address: _____

   City: _____ State: _____ Zip: _____
4. Phone Number: (___) _____ 5. Employer: _____
6. Last day you worked: _____ 7. Date returned: _____ or estimated return _____
8. Reason you are unable to work? _____ Injury Illness

   If injury, please complete the following: Date of injury: _____

   Auto Accident? YES NO
   If YES, have you filed a claim for loss of wages through auto insurance? YES NO

   On the Job? YES NO
   If YES, have you applied for Worker's Compensation? YES NO
   If NO, do you intend to apply? YES NO

   Brief description of event/injury: _____

   _____
9. Have you applied for Social Security Disability? YES NO
   If NO, do you intend to apply? YES NO

EMPLOYER - COMPLETE THIS SECTION

Last Day Worked: _____ First Date Excused: _____ Date Returned: _____

Current Hourly Rate: $ _____ Number of hour's employee is scheduled per week? _____

Job Status when disability began: Full-time FMLA On Sick Leave Leave of Absence Term Laid Off

Is there any work available for the employee with his/her limitations? YES NO

If YES, has the employee been offered this position? YES NO
If YES, has the employee denied this work? YES NO

Has the employee qualified for Worker's Compensation? YES NO

Has the employee qualified for State Disability? YES NO

Form completed by (please print name): _____

_____ (___) _____ (___) _____ _____
Signature Phone Number FAX Number Date

Comments: _____

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TIME LOSS CLAIM RULES AND REGULATIONS

To receive any Time Loss benefits, the attached application including the Physician's verification must be completed and returned to the Trust office. The following limitations apply to all Time Loss claims. Please consult your Plan Booklet for complete benefits.

Time Loss for an illness (*pregnancy included*) does not begin until the sixth (6th) working day. Time Loss for an accident or injury will begin on the first (1st) working day. **If you are off work due to a work injury, please attach a copy of your worker's compensation payment information.**

While you are off work, your employer is not required to pay for your benefits. Please verify coverage with the Trust office prior to receiving any services (i.e. vacation, sick pay) during the time you are collecting time loss benefits.

On the date that the employee is released by the doctor for return to work the employee will no longer be considered "continually totally disabled". The Trust will not waive premium for any month with respect to which the employee could have worked 80 hours.

The Trust issues Time Loss checks for not more than two weeks at a time (unless original application) and checks are not issued in advance for time to be missed. Checks will automatically be mailed**. Please allow at least 10 working days for your claim to be processed.**

Federal law which became effective on January 1, 1982 requires the Trust to withhold FICA tax on Gross Time Loss benefits payable to employees pursuant to a plan established by an employer. Under the new law, Time Loss benefits are taxed until six (6) months after the last calendar month during which you worked for your employer. Federal Law also allows the Trust to withhold Federal Withholding taxes **IF** the employee elects to do so on Form W-4S. The Trust will not withhold Federal Withholdings if Form W-4S is not returned.

The Trust will consider a claim timely filed if the claim is received by the Trust office within one year of the date of disability. A claim is considered filed on the day the claim is received at the Trust office. Claims may be filed by mail properly addressed and postage prepaid; by delivery to the Trust during regular office hours; or by facsimile.

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I hereby authorize my physician, hospital, or medical care service provider to provide the United Employees Benefit Trust, its employees, agents, attorney or advisors all information which it or they may request regarding my physical or mental condition and any treatment therefore, including copies of any medical records, dental records or x-rays as required to process claims submitted by me.

I have read the above and understand that any benefit paid for this claim is based upon the above information and I hereby certify that such information is true and accurate to the best of my knowledge.

_____ _____

Member Signature - *required to receive benefits* **Date**

UEBT
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PHYSICIANS VERIFICATION FOR TIME LOSS CLAIM

Dear Physician: Our member/your patient has applied for short term disability insurance. Please assist your patient by completing this form in its entirety and returning it to the Trust office. Any fees associated with the completion of this form are the responsibility of the patient. Thank you for your assistance.

1. Employee/Patient's name: _____
2. Employer: _____ SSN or UID#: _____
3. Diagnosis: _____ Illness Injury
4. Date you first treated patient for this condition? _____
5. Date condition commenced? _____ First day unable to work? _____
6. If pregnancy, estimated delivery date? _____
7. Is condition due to patient's employment? YES NO
   If YES, have you completed a Worker's Compensation form? YES NO
8. Regimen of treatment to be prescribed (indicate number of visits, general nature and duration of treatment, including referral to other providers of health services). _____
   _____
   _____
9. Is the patient able to perform his regular work? YES NO
   If NO, please describe his/her work limitations, or any other applicable limitations: _____
   _____
   _____
10. Length of disability? From _____ through _____
    (Stating present, current or unknown will only authorize disability through the date this form is signed)
11. Comments: _____
    _____
    _____

Physicians Signature: _____ Date: _____

Physicians Name (printed): _____

Phone Number: (___) _____ Fax Number: (___) _____

Physicians Mailing Address: _____

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PROCEDURES FOR COMPLETION OF TIME LOSS APPLICATION

If, while you are an eligible employee, you become wholly and totally disabled due to an illness or injury you may apply for Time Loss benefits. In order to apply for benefits you must complete or have completed on your behalf the attached forms.

TIME LOSS RULES and REGULATIONS

This form must be signed and returned with your Application to receive benefits.

TIME LOSS CLAIM APPLICATION

You must complete the top portion of this form completely and have your employer complete the bottom. All questions must be answered, if they do not apply please indicate such.

PHYSICIAN'S VERIFICATION FORM

This form must be filled out in its entirety by your physician. You may leave this form with your physician and have his/her office return the form to the Trust, however, please be aware that we are unable to process any applications until all forms are returned.

FORM W-4S - Federal Withholding

Your time loss benefits are **taxable income** and are reported to your employer. The amounts collected will be included in the IRS Form W-2 from your employer at the end of the year. You may elect to have Federal Income Tax Withholding taken out of your time loss benefits, but it is not required. If you wish to have withholdings taken, please complete IRS Form W-4S.

The Federal Income Tax minimum withholding is $20.00 per week. The box on the form asks you to enter "the amount to be withheld for each payment." Time Loss is paid on a bi-weekly basis, making the minimum amount allowed in this box to be $40.00. ($20 per week x 2 weeks of benefits = $40) If you do not return Form W-4S with your application UEBT will not take any withholdings.

WHERE TO SUBMIT COMPLETED CLAIM:

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WHEN CAN YOU EXPECT TO RECEIVE A BENEFIT CHECK?

Benefit checks are issued every other week.

QUESTIONS:

If you have any questions while completing this application or regarding your benefits, please do not hesitate to call our office at (253) 474-1214 or (800) 223-2449.

IT IS YOUR RESPONSIBILITY TO MAKE SURE THAT ALL INFORMATION IS COMPLETE AND RETURNED TO THE TRUST. WE ARE UNABLE TO PROCESS ANY APPLICATIONS THAT ARE NOT COMPLETED IN THERE ENTIRETY.

Revised 1/2017