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

*220 S 27th St #B * Tacoma WA 98402*
(253) 474-1214 or (800) 223-2449
Fax: (253) 474-7180
E-mail: staff@unitedemployees.org
Website: www.unitedemployees.org

APPLICATION FOR WAIVER OF PREMIUM

Insured Name: _____

Insured ID#: _____

Even though eligibility for Medical benefits would otherwise terminate, benefit coverage will be extended for up to three months without payment of any premium if you became and remained ineligible because of "total disability". This form must be completed in order to receive waiver of premium.

Nature of Disability: ☐ Work Injury ☐ Off-Job Injury ☐ Illness ☐ Pregnancy

Date of Injury: _____ Time: _____

First full working day you were unable to work: _____

Were you employed on the first day missed? ☐ Yes ☐ No

Have you applied for FMLA? ☐ Yes ☐ No Have you applied for pension? ☐ Yes ☐ No

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PHYSICIAN TO COMPLETE THIS PORTION

First date excused: _____ First date seen: _____

Estimated date of release: _____

Diagnosis: _____

Prognosis: _____

Comments: _____

Physicans Name, Address and Phone (please print): _____

_____

_____ _____

Physicians Signature Date