New York City District Council of Carpenters

BENEFIT FUNDS

395 Hudson Street
New York, NY 10014
Telephone: (212) 366-7300

Dear Participant:

Enclosed please find an application for Short-Term Disability (”STD”) benefits. This benefit is administered by the New York City District Council of Carpenters Welfare Fund (the “Welfare Fund”). Please complete, sign, and answer **ALL** questions on **Part A** of the form. **Part B** is to be completed and signed by your attending physician. In order to verify your wages, <u>you will need to provide the Welfare Fund copies of your pay stubs for the 8-week period immediately prior to the onset of your disability</u>.

The Welfare Fund requires STD benefits to be directly deposited to your banking account. Please sign and provide your banking information on the enclosed Direct Deposit form. **If the Welfare Fund is not provided with banking information, your STD benefit will be paid to the banking account used for your Vacation benefit.**

Once your application has been approved for payment, **your first payment will be mailed directly to you in check format and the following payments will be deposited directly** into the bank account you provided on the enclosed form.

Please submit all completed documents together, along with the signed Direct Deposit form, to the Welfare Fund. You may mail it to the attention of the Welfare Fund at 395 Hudson Street, New York, NY 10014 or fax it to (212) 366-3301. Upon receipt of your application, we will determine your eligibility for these benefits and process payment if eligible.

Benefits are payable as long as you remain disabled, up to a maximum of 26 weeks of disability in any 52-week period. Please note, if you return to work prior to the date indicated by your physician, you are required to contact the Welfare Fund office immediately to stop your STD benefits. You will be responsible to pay back the Fund any STD benefits received during the time wages were reported by your employer.

In the event your disability continues beyond an initial 26-week period and you have more than 5 vesting credits toward your pension, you may be entitled to a disability benefit from the NYCDCC Pension Fund. You may contact the Welfare Fund to initiate your pension application.

For more information concerning Welfare and Pension benefits, please visit our website at **www.nyccbf.com**. If you have any questions, please contact the Welfare Fund at (800) 529-3863 and we will be happy to assist you.

Sincerely,

NYCDCC Welfare Fund

New York City District Council of Carpenters Welfare Fund

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

Read instructions on page 2 carefully to avoid a delay in processing. You **must answer all questions in Part A** and questions **1 through 3 in Part B.** Health care providers must complete Part B on page 2.

PART A - CLAIMANT'S INFORMATION (Please Print or Type)

1. Last Name: ____ First Name:________________________________ MI: ______
2. Mailing Address (Street & Apt. #): ____
   City: _________________ State: _____________ Zip:_____________
3. Daytime Phone #: _______________________________ Email Address: ______________________________________
4. Social Security #: ______-____-_______ UBC:________________ 5. Date of Birth: ______/____/________ 6. Gender: M __ F __
7. Describe your disability (if injury, also state how, when and where it occurred): _______________________________________
   ____
8. Date you became disabled: ______/____/________ Did you work on that day?: Yes ___ No ___
   Have you recovered from this disability?: Yes ___ No: ___ If yes, date you were able to return to work: ______/____/________
   Have you since worked for wages or profit?: Yes ___ No ___ If yes, list dates: _______________________________________
9. Name of last employer prior to disability. If more than one employer in previous eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

LAST EMPLOYER PRIOR TO DISABILITY			PERIOD OF EMPLOYMENT		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Employer Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
OTHER EMPLOYER (during last eight (8) weeks)			**PERIOD OF EMPLOYMENT**		**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
Employer Name	Address	Phone Number	First Day	Last Day Worked	
			Mo. Day Yr.	Mo. Day Yr.	
			Mo. Day Yr.	Mo. Day Yr.	

10. My job is or was: _______________________ 11. Union Member: Yes___ No ___ Union Local #:__________
12. Were you claiming or receiving unemployment prior to this disability?: Yes ___ No ___
    If you did **not** claim or if you claimed but did **not** receive unemployment insurance benefits *after* LAST DAY WORKED, explain reasons fully: ____
    ____
    If you did receive unemployment benefits after LAST DAY WORKED, provide all periods collected: ________________
    ____
13. For the period of disability covered by this claim:
    A. Are you receiving wages, salary or separation pay? Yes ___ No ___
    B. Are you receiving or claiming:
       1. unemployment Benefits? Yes ___ No ___ 2. Paid Family Leave? Yes ___ No ___
       3. Workers' Compensation for work-related disability? Yes ___ No ___
       4. No-Fault motor vehicle accident? Yes ___ No ___ or Personal Injury? Yes ___ No ___
       5. Long-term disability benefits under the Federal Social Security Act for *this* disability? Yes___ No ___

    IF "YES" IS CHECKED IN ANY OF THE ITEMS IN QUESTION 13, COMPLETE THE FOLLOWING:

    I have received claims from ____/____/____ for the period: ___/___/___ to: ___/___/___
14. In the year (52 weeks) before your disability began, have you received disability benefits for the other periods of disability?
    Yes ___ No ___ If Yes, please provide dates: From: ___/___/___ to: ___/___/___
15. In the year (52 weeks) before your disability began, have you received Paid Family Leave?
    Yes ___ No ___ If Yes, please provide dates: From: ___/___/___ to: ___/___/___

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I have read the instructions on page 2 of this form and that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

____ ___________________________

Claimant's Signature **Date**

An individual may sign on behalf of the claimant only if he or she is legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated.

____

On behalf of Claimant **Address** **Relationship to Claimant** **Date**

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM. For item 7-d, you must give estimated date. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 7-e. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS**.

1. Patient's Last Name: ____________________________ Patient's First Name: _____________________________ MI: _____

2. Gender: M ___ F ___ 3. Patient's Date of Birth: ____/____/_______

4. Diagnosis/Analysis: Diagnosis Code: ________________

a. Claimant's Symptoms: ____

____

b. Objective findings: ____

____

5. Claimant hospitalized?: Yes ___ No___ From ____/____/_______ To ____/____/_______

6. Operation indicated?: Yes ___ No ___ a. Type: _______________________ b. Date ____/____/_______

7.	ENTER DATES FOR THE FOLLOWING	MONTH	DAY	YEAR
a.	Date of your first treatment for this disability			
b.	Date of your most recent treatment for this disability			
c.	Date Claimant was unable to work because of this disability			
d.	Date Claimant will again be able to perform work (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)			
e.	If pregnancy related, please check box and enter the date estimated delivery date OR actual delivery date			

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?: Yes ___ No ___ If "Yes", has the form C-4 been filed with the Board?: Yes ___ No ___

I certify that I am a:

(Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife) ________________ **Licensed or Certified in the State of** ________________ **License Number** ________________

Health Care Provider's Printed Name ________________ **Health Care Provider's Signature** ________________ **Date** ________________

Health Care Provider's Address ________________ **Phone #** ________________

IMPORTANT NOTICE TO CLAIMANT - READ THESE INSTRUCTIONS CAREFULLY

PLEASE NOTE: Do not date and file this form prior to your first date of disability. In order for your claim to be processed, Parts A and B must be completed.

1. If you are using this form because you became disabled **while employed** or you became disabled **within four (4) weeks after termination of employment**, your completed STD application along with a Direct Deposit Form, PHI Authorization Form and copies of your 8 most recent paystubs should be mailed **within thirty (30) days of your first date of disability to the NYCDCC Welfare Fund, Attention Disability, 395 Hudson Street, New York, NY 10014 fax: (212) 366-3301**

2. If you are using this form because you became **disabled after having been unemployed for more than four (4) weeks**, you need to submit a disability claim, DB450 with Workers' Compensation Board. Please visit www.wcb.ny.gov to obtain a DB450 disability claim form and mail your claim to: **Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029**. If you answered "Yes" to question 13.B.3, please complete and attach Form DB-450.1 from www.wcb.ny.gov and submit the document directly to **Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029**

Direct Deposit: payments will be paid via wire to your bank account. Make sure you submit a Direct Deposit Authorization form and verify that all banking information is accurate. If no authorization form has been submitted, if applicable, the deposit will go into the banking account that your vacation benefit is wired to.

Disclosure of Information: The Welfare Fund will not disclose any information about you case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized party, you must fill out and sign a Disclosure of Protected Health Information Authorization release form. The form was provided to you along with this application. If one was not provided, you can request the form by contacting the Welfare Fund (212) 366-7300

If you do not receive a response within 45 days or if you have questions about your disability benefits claim, please call NYCDCC Member Services (212) 366-7300. For general information about disability benefits, please visit www.wcb.ny.gov or call the Board's Disability Benefits Bureau at (877) 632-4996.

NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS WELFARE FUND

AUTHORIZATION FORM

For Use of Disclosure of Protected Health Information

PURPOSE OF THIS FORM

Under the Health Insurance Portability & Accountability Act (HIPAA), in order for the Welfare Fund to use or disclose Protected Health Information to someone other than you, you must complete this Authorization Form and return it to the Fund.

Protected Health Information "PHI" is information that is created, received, transmitted or stored by the Fund which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. Except as permitted by law, the Fund may not use or disclose PHI to persons other than those you specify on this form.

The Fund may request that you complete this form where the use of disclosure of information is necessary to carry out functions of the Fund. In addition, you may submit this form to the Fund because you want someone to request or receive your PHI from the Fund. This form is not needed if you are requesting your own PHI from the Fund.

Name: ________________________ UBC#________________________

I hereby give permission to the Welfare Fund, or any of its affiliates or agents and their staff performing services in connection with my claim for health plan benefits, to disclose my protected health information (PHI) identified in Section #3 of this Form to the following class persons:

Spouse________________________

Employer or the Fund New York City District Council of Carpenters Pension Fund________________

Business Manager, Union Official or Agent________________________

Other Person(s) New York County Health Services Review Organization/Med Review______________

I authorize the Welfare Fund to disclose PHI (including written, electronic, or oral information) to the person(s) identified in Section #2 of this form in connection with (mark all that apply): (if you want different people to have access to different information, you must fill out separate forms.)

__ Hospital/Medical Claims __ Prescription Drug Claims __Vision Claims
__ Mental Health Claims __ Dental Claims __ Hearing Aid Claims
__ Specific claim for health benefits __ Disability Claim information
(describe the event or claims involved with the date of service)

____

____

The purpose of the use of disclosure of my protected health information (PHI) is:

____

____

____

NOTE: "at the request of the individual" is a sufficient description of the purpose.

This Authorization form is valid until:

1. ____ (please provide date of event);
2. The date the Fund receives my Cancellation of Authorization Form; or
3. If not otherwise indicated in (1) above, one year from the date I sign this form.

I understand that:

- I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION FORM.
- I HAVE THE RIGHT TO REVOKE THIS FORM AT ANY TIME BY SUBMITTING A CANCELLATION OF AUTHORIZATION FORM TOP THE WELFARE FUND. CANCELLATION WILL TAKE EFFECT AS OF THE CANCELLATION DATE OR EVENT, OR ONCE THE WELFARE FUND RECEIVES THE CANCELLATION OF AUTHORIZATION FORM.
- THE PERSON(S) I AM AUTHORIZING TO RECEIVE MY PHI MAY NOT BE REQUIRED TO TREAT THIS INFORMATION AS CONFIDENTIAL.
- TREATMENT, PAYMENT, ENROLLMENT AND ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON OBTAINING AN AUTHORIZATION.

____ _______________________________

Your Signature (or Signature of Personal Representative*) Date

*If you are acting as the personal representative of the individual whose PHI is to be disclosed, you must provide proof of your authority to act for that individual.

New York City District Council of Carpenters

BENEFIT FUNDS

395 Hudson Street
New York, NY 10014
Telephone: (212) 366-7300

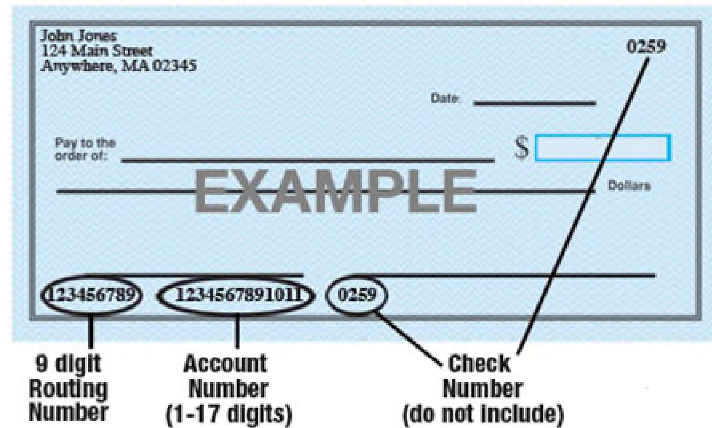
Direct Deposit Authorization Form

Please print and complete ALL the information below for Short Term Disability Direct Deposits

Name: ______________________________**UBC:** ___________________________

Address: ______________________________**City, State, Zip**:___________________

Cell Phone: ______________________________ **Email:** __________________________



Name of Bank: ____

Account #: ____

9-Digit Routing #: ____

Type of Account: ☐ Checking ☐ Savings ☐ Vacation Benefit Account (Check One)

Attach a voided check for bank account to which funds should be deposited (if necessary)

If a Direct Deposit form is not provided along with your disability application, payments will be deposited into the account set up for your Vacation benefit payment.

NYCDCC Welfare Fund is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee's Signature: ________________________________Date:___________________________