Local 282 Welfare Trust Fund

2500 MARCUS AVENUE, LAKE SUCCESS, NY 11042 (516) 488-2822 (718) 343-3322 Fax (516) 488-4490

EXTENDED LIFE INSURANCE BENEFIT CLAIM FORM

To be completed by member (Please Print or Type)

1) ______________________________ Last Name First MI

2) ______________ Social Security No.

3) ______________________________ Street Address City State Zip Code

4) Date of Birth ________ ________ ________ Month Day Year

(Attach birth certificate or other proof, originals will be returned)

5) ______________________________ Employer's Name Address

6) Date employment commenced with employer ______________ Month Day Year

7) Job classification ______________

8) Last Day Worked ______________

9) Did You File for Weekly Accident and Sickness Benefits with the Welfare Fund? ☐ Yes ☐ No

10) Do you plan to return to your previous type of employment ________ or in any type of job? ________;

If yes, approximate date ________ . Do you have any income from self-employment? ☐ Yes No ☐

11) Physician's Name ______________________________

Address ______________________________

A FULLY COMPLETED PHYSICIAN'S STATEMENT MUST ACCOMPANY THIS FORM OR MAY BE MAILED DIRECTLY TO THE WELFARE FUND BY YOUR PHYSICIAN.

I hereby state that the above information is correct and true to the best of my knowledge and I understand that if I am eligible all benefits will be made in accordance with the Local 282 Welfare Trust Fund Rules and Regulations pertaining to Extended Life Insurance Provisions. Further, I authorize the Trustees to contact my physician(s) in order to obtain medical evidence as they may deem necessary to determine my eligibility and rights to benefits.

______________ Date ______________________________ Member's Signature

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