U.A. LOCAL 467 SHORT TERM DISABILITY PLAN

(Weekly Indemnity)

Return completed form to:

UNITED ADMINISTRATIVE SERVICES
P.O. Box 5057 - Zip 95150
1120 South Bascom Avenue
San Jose, California 95128

PART I - To be completed by INSURED EMPLOYEE (Each question must be fully answered) Member's Phone # _____

1. Name _____ 2. Birth date _____ S.S. No. _____
   Street _____ 3. Last date of work before disability _____
   City and State _____ Zip code _____
4. My disability is _____ Injury? _____
   Illness? _____
5. It happened: Date _____ At Work? _____
   Time _____ At Home? _____
6. How did it happen? _____

To Physicians and Hospitals and Other Institutions: I hereby authorize you by this form (or by photographic copy hereof) to give Local 467 Trust Fund any information you have regarding my medical history and physical condition.

I certify the above answers are true and complete to the best of my knowledge and belief.

Dated _____ Mr. _____ Mrs. _____ Miss _____ _____
SIGNATURE - Please Do Not Print

PART II - ATTENDING PHYSICIAN'S STATEMENT

1. Nature of sickness or injury (Describe complications, if any) _____
2. Was this sickness or injury caused by patient's employment? Yes _____ No _____
   Illness? _____ Injury? _____
   Was it aggravated by Patient's employment? If "Yes" explain _____
3. Nature of surgical procedure, if any (Describe fully) _____
4. Date performed: _____ ,year _____
5. Give dates of treatments:

	FIRST CONSULTATION	OTHER CONSULTATIONS DURING THIS PERIOD OF DISABILITY
Office		
Home		
Hospital		

6. The patient has been continuously disabled (unable to work) from _____ ,year _____
   through _____ ,year _____
   If still disabled, when should patient be able to return to work? _____ ,year _____
7. Remarks _____

DATED _____ Physician's Name (Print) _____ Degree _____
Physician's Signature _____
Address _____
Physician's Phone Number _____

PART III - TO BE COMPLETED BY ADMINISTRATOR

EFFECTIVE DATE OF INSURANCE _____ VERIFIED BY _____