ILWU-PMA WELFARE PLAN CLAIM FORM
FOR CSDI DISABILITY SUPPLEMENT

Mail Completed Form To: **ILWU-PMA COASTWISE CLAIMS OFFICE**
814 MISSION STREET, SUITE 300
SAN FRANCISCO, CA 94103

PART 1 - EMPLOYEE STATEMENT *(Fill out and attach your CSDI check stub(s).)*

1. NAME	2. LOCAL NUMBER	3. REGISTRATION NUMBER	4. SOCIAL SECURITY NUMBER

5. ADDRESS (Street, City, and Zip Code)

6. ON WHAT DATE DID YOU LAST WORK BEFORE THIS DISABILITY?	7. HAS YOUR DISABILITY ENDED? **YES** ☐ **NO** ☐	8. IF YES, GIVE DATE YOU WERE AVAILABLE FOR WORK

9. IS DISABILITY DUE TO AN ACCIDENT? **YES** ☐ **NO** ☐	11. WHERE AND HOW?
10. IF YES, DATE	

12. IS YOUR DISABILITY DUE TO AN ACCIDENT, INJURY, OR ILLNESS ARISING OUT OF EMPLOYMENT? **YES** ☐ **NO** ☐	13. IF ANSWER TO 11. IS YES, HAVE YOU FILED, OR DO YOU INTEND TO FILE, A CLAIM FOR BENEFITS UNDER ANY FEDERAL OR STATE WORKERS' COMPENSATION LAW? **YES** ☐ **NO** ☐
14. IS YOUR DISABILITY DUE TO AN ACCIDENT, INJURY, OR ILLNESS ARISING CAUSED BY SOME OTHER PARTY? **YES** ☐ **NO** ☐	15. IF ANSWER TO 13. IS YES, HAVE YOU FILED OR DO YOU INTEND TO FILE, ANY LEGAL ACTION OR CLAIM AGAINST THE OTHER PARTY? **YES** ☐ **NO** ☐

The above answers are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution, druggist, insurance company, employer, labor union, or association to release information to ILWU-PMA Coastwise Claims Office as is required to properly pay all benefits, if any, due me for this claim.

DATE________________, **20**______ **SIGNATURE** ______________________________
EMPLOYEE

PART 2 - FOR OFFICE USE ONLY

DATE OF BIRTH	**SOCIAL SECURITY NUMBER**

ELIGIBLE:
YES ☐ **NO** ☐ **E/D:** ________________

STATUS:

ACTIVE: ____________

RETIRED: **Disability** ☐
Normal ☐ **E/D:** ________________

TRANSMITTED: ________________ **BY:** ____________________________

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