ILWU-PMA WELFARE PLAN

CLAIM FORM FOR ELIGIBILITY EFFECTIVE _____________

RE: Name ___________________________ Local _____ Reg. No. ________________

1. Absence(s) due to disability:

From ___________________________ To ___________________________
From ___________________________ To ___________________________
From ___________________________ To ___________________________

Check applicable box below and attach required items:

☐ Absence due to disability for a portion of the review period - applicable if hours worked = 25% or more of hours required for eligibility. Doctor's certification verifying dates of disability must be attached. (Doctor must be an MD, DO, DPM, DC, RPT, Ph.D., Psy.D., LCSW, MFCC, LAc, MFT, CMHC, BCSW, DDS, RNP, CRNA, PA, OD, Nurse Midwife, occupational therapist, speech pathologist, audiologist, or registered nurse with a Masters Degree in psychiatric mental health nursing)

☐ Continuous absence due to a job-connected illness or injury for which industrial compensation is received. Evidence of industrial compensation and doctor's certification specifying dates of disability must be attached.

☐ Continuous absence due to any other illness or injury which is not specified above. Doctor's certification verifying dates of disability must be attached.

2. Leave(s) of absence under 90 days: (For reason other than illness)

From ___________________________ To ___________________________

3. Amputee due to on-the-job injury:

Effective Date ___________________________. Check whether or not claimant was available for work as condition permitted. YES ☐ NO ☐

4. Social Security Retirement: Effective Date __________________________

5. Military Duty: From ___________________________ To ___________________________

JLRC Signature:

Union Signature Date Employer Signature Date

Mail to: ILWU-PMA Benefit Plans
1188 Franklin Street – Suite 101
San Francisco, CA 94109

NOTE: Industrial Compensation documents submitted with this claim will be automatically reviewed by the Benefit Plans office for Pension credit.