SOUTH FLORIDA HOTEL AND CULINARY EMPLOYEES WELFARE FUND

c/o NATIONAL EMPLOYEE BENEFIT ADMINISTRATORS
2010 NW 150th Avenue, Suite 200, Pembroke Pines, FL 33028
Phone (833) 304-0380 Fax (954) 266-2079

Short Term Disability Benefit Application

Part A: To Be Completed by the Participant Claiming Benefit for Self					
1.	Employee Name		2.	Social Security Number	
3.	Date of Birth		4.	Telephone Number	( ) -
5.	Address				
6.	Email Address		7.	Hourly Rate of Pay	
8.	Is claim for a job related injury or illness?	YES / NO Please circle response	9.	Have you filed for Worker's Compensation?	YES / NO Please circle response
10.	Please provide Name, Phone Number and Claim Number for any applicable Workers Compensation carrier				

The above answers are true and complete according to the best of my knowledge and belief. I authorize any employers, insurance company, dental / medical prepayment plan, employee welfare benefit (including the Fund), service organization, physician, practitioner or other person and hospital, including the Veteran's Administration or other Institution, to release or, obtain any medical / dental or benefit information that may be required to establish or support the validity of this claim, and further authorize said company, person or organization (including the Fund) in its discretion, to disclose to any other person, company organization so requesting any of my personal dental / medical or claim information obtained in any case study or claim review. A copy of this authorization shall be as valid as the original. I also acknowledge the subrogation right of the Plan and agree to repay any sums expended by the Plan for injury or sickness if I receive payment from another party or source. "See Summary Plan Description"

Employee Signature:_____ Date: _____

See reverse side for Part B

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Part B: Attending Physician's Statement					
1.	Patient Name		2.	Date of Birth	
3.	Date of Illness (First Symptom), Injury (Accident) or Pregnancy (LMP)		4.	Date of First Consultation for This Condition	
5.	Date Patient Able to Return to Work (Without Restrictions)		6.	Dates of Total Disability (Estimate if Necessary)	
7.	Name of Referring Physician		8.	Name and Location of Facility (if applicable)	
9.	Diagnosis or Nature of Illness or Injury	1. 2.			
10.	Signature of Physician	Signature:_____ Date: _____			
11.	Physician's Name, Address, Zip Code and Phone Number				

Part C: Employer's Statement (Employer Must Complete In Full)					
1.	Last Date Worked		2.	Date Returned to Work *(or Expected Return Date)*	
3.	Is this disability the result of a work related injury/illness?		4.	Will a claim be made under Worker's Compensation?	
5.	Employee's Hourly Rate of Pay		6.	Average Number of Hours Worked Per Week	
Date Signed		Signature			