

Theatrical Stage Employees Health & Welfare Trust

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Administered by
Welfare & Pension Administration Service, Inc.

APPLICATION FOR TEMPORARY TRUST-PAID BENEFITS COVERAGE DUE TO DISABILITY

The Theatrical Stage Employees Health and Welfare Trust provides that if a participant becomes disabled and is unable to perform his/her duties as a stage employee, premiums will be waived for medical, dental, vision, life/ad&d coverage for the length of the disability, not to exceed six (6) months. This payment will include the cost of dependent coverage if that coverage was in effect at the time of the disability. Confirmation of disability must be provided within 60 days of the onset of disability to qualify for the premium waiver. **A Disability Application must be filed with Welfare & Pension Administration Service, Inc., within 60 days of the date of the disability. Failure to provide a complete application within that timeframe would result in not qualifying for the Trust-Paid Benefits Coverage.**

Each application submitted only qualifies a member for up to three (3) months of disability coverage. Two applications must be made to qualify for the full six months of the premium waiver. A second application must be submitted within 60 days from the last day of the prior provided premium waiver coverage. More instructions can be obtained at www.ia15trust.com.

“Disability” is defined as the inability to perform one’s “own occupation,” which is any employment, business, trade, profession, calling, or vocation which involves the Material Duties of the same character as the regular and ordinary employment with the Employer. “Own Occupation” is not limited to the participant’s job with the Employer. “Material Duties” means the essential tasks, functions, and operations, and the skills, abilities, knowledge, training, and experience generally required by the employers from those engaged in a particular occupation.

Please note, to receive the Short Term Disability (STD) income replacement benefit, you must complete the separate STD claim packet and submit to Sun Life Financial. The STD claim packet can be found online at www.ia15trust.com.

This application consists of three parts. All parts must be completed before Trust-Paid Coverage can begin.

1. TO BE COMPLETED BY EMPLOYEE

I hereby certify that I am disabled and unable to perform my occupation as a stage employee.

Name: _____ Social Security No. _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

Date last worked: _____ Last Employer: _____

Signature: _____ Date: _____

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(continued)

2. TO BE COMPLETED BY PHYSICIAN

I hereby certify that I attended the individual named above on the dates listed below, and that he/she has been continuously disabled from performing his "own occupation" from _____ to _____. As described below.

Primary Diagnosis: _____ ICD-9 Code: _____

Secondary Diagnosis (if applicable): _____ ICD-9 Code: _____

Start Date of Disability: _____ Date of first office visit: _____

Date of last office visit: _____ Date of next office visit: _____

Prognosis: _____

Date patient may return to occupation part-time: _____

Date patient may return to occupation full-time: _____

Name of Physician: _____ Specialty: _____

Address: _____

Tax ID #: _____ Phone: _____

Signature of Physician: _____ Date: _____

3. TO BE COMPLETED BY UNION REPRESENTATIVE

I hereby certify that the above-named member has not worked from _____
(insert date)

through _____ due to the disability described above.
(insert date)

Member's Job Title: _____

Date last worked before disability: _____ Hours worked last day: _____

Signature: _____ Date: _____

Print Name and Title: _____