1199SEIU
Benefit and Pension Funds

330 West 42nd Street
New York, NY 10036

Member ID _____

Name _____

Employer's Disability Statement

1. Date Employed _____ Regular Weekly Wage $: _____
2. Date Last Worked (Before Disability) _____
   A. Full Sick Pay Received, Not The 1/3 Sick Pay Provided In The Union Contract.
   Period: From _____ To _____
   B. Vacation Pay Received: From _____ To _____
3. Has Employee Returned to Work? ❑ Yes ❑ No Date _____
4. Is this claim covered by Workers' Compensation? ❑ Yes ❑ No
5. Name of Employer _____
6. Authorized Signature _____
7. Title _____ Phone Number _____
8. Weekly Wages: List Member's Gross Earnings during each of the last eight calendar weeks prior to week in which disability began.

Week Ending _____ Number of _____

Month _____ Day _____ Year _____ Days Worked _____ Amount _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____