CALIFORNIA SERVICE EMPLOYEES HEALTH and WELFARE TRUST FUND

828 W Washington Boulevard, Los Angeles, CA 90015
Telephone (213) 747-7551 or (877) 492-2778

To: **Participants in the California Service Employees Health & Welfare Trust Fund**

From: **Board of Trustees**

Re: **Rules Affecting Disabled Participants**

These rules will allow your Health and Welfare coverage to be continued for a limited time if you are disabled and unable to work sufficient hours to earn eligibility. If you are disabled, your eligibility will be continued even though your employer is not making a contribution to the Trust Fund on your behalf as long as you remain disabled. In order to qualify for the disability extension of eligibility, you must have been eligible for Health and Welfare benefits before your disability began, and you must submit a doctor's written certification of your disability.

The length of the disability extension will depend on the amount of time you were eligible under the Trust Fund before you became disabled, as shown below:

If you were previously eligible for:	You and your eligible family members will continue to be eligible for all Fund benefits for:
At least 12 months but less than 24 months of consecutive coverage with the Plan	3 months starting with the first month you would have lost eligibility
24 months of consecutive coverage with the Plan	6 months starting with the first month you would have lost eligibility

If you have any questions, please call the Trust Fund office at (213) 747-7551 or toll free (877) 492-2778.

Sincerely,

BOARD of TRUSTEES

CALIFORNIA SERVICE EMPLOYEES HEALTH and WELFARE TRUST FUND

828 W Washington Boulevard, Los Angeles, CA 90015
Telephone (213) 747-7551 or (877) 492-2778

DATE: _____

NAME: _____

SS#: _____

EMPLOYER: _____

RE: DETERMINATION OF DISABILITY STATUS FOR FUND PAYMENT

To Proceed with your claims, additional information is needed. Please furnish the following information in order that we may establish the disability status for FUND PAYMENT.

If you, the insured member have been unable to work because of a total disability, please have your Physician certify the nature and inclusive date of this total disability.

PLEASE HAVE YOUR PHYSICIAN COMPLETE THE PORTION BELOW

Dates of TOTAL DISABILITY (Unable to work):

FROM:_____ THROUGH:_____

Diagnosis or Nature of Illness or Injury:_____

_____

Is this a result of injury/illness on the job: Yes_____ No_____

PHYSICIAN'S NAME, ADDRESS, ZIP CODE AND TELPHONE NUMBER:

Name:_____

Address:_____

City, State & Zip Code:_____

Telephone No:_____

_____ _____
Signature of Physician Date