U. A. UNION LOCAL 290 PLUMBER, STEAMFITTER & SHIPFITTER INDUSTRY HEALTH & WELFARE TRUST

12205 SW Tualatin Rd., Suite 200
Tualatin, OR 97062
Phone (503) 486-2104 * (866) 796-2305 * Fax (971) 239-0671
www.zenith-american.com

Dear Member,

You have requested a form to file for weekly disability benefits under U.A. Union Local 290 Plumber, Steamfitter & Shipfitter Industry Health & Welfare Trust. This packet contains the information you will need to submit your weekly disability benefit claim. Please find the following documents enclosed:

1- Frequently Asked Questions
2- Common Reasons for Delays & Plan Explanation (2 pages)
3- Blank Statement of Weekly Disability Benefit Form
4- Request for Update on Weekly Disability Benefit Form
5- Authorization Release Form (2 pages)
6- Special Instructions for Weekly Disability Benefits Due to COVID-19 or Exposure
7- COVID-19 Statement of Disability Claim Form

In order for your weekly disability benefit claim to be processed, the claim form must be filled out entirely to ensure no delays occur in the processing of your claim for weekly disability benefits. You are responsible for filling out the top portion of the form, while your physician will fill out the other section. If your physician states return to work is "Present", "Unknown", or "Undetermined", weekly disability benefits will only be paid to the date of the physician's signature.

For weekly disability benefits due to COVID-19 or exposure, the COVID-19 claim form must be filled out by you and your physician, employer or UA 290 Dispatch must fill out the appropriate other sections.

When you are getting close to your return to work date established by your physician, we will send you a letter for your physician to update your return to work status if anything has changed.

Disclaimer: This is not a guarantee of weekly disability benefits. Please refer to the Summary Plan Description (SPD) for additional benefit information.

If you have any questions, please contact the Trust Office, where a Claims Representative will be happy to assist you.

Thank you,

Claims Department
(503) 486-2104
ZA-Claims-PDX@zenith-american.com

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Frequently Asked Questions

Q: Why should I complete the Statement of Disability?
A: By completing the form, you will receive a weekly income benefit which will be used as a basis to continue your insurance coverage.

Q: How long can I receive a weekly disability benefit?
A: You may be entitled to a weekly disability benefit for any period of disability of $730.00 per a week for the first 26 weeks, and then $585 per week for the 27th through the 52nd week.

Q: Does the employee need to complete the weekly disability claim form?
A: Yes-Part 1 is completed by the employee and Part 2 is completed by the physician.

Q: Is there a waiting period?
A: Benefit begins on the eighth day of disability due to an illness and on the first day of disability due to an accident. However, if you are confined as an inpatient in a hospital or have surgery in an outpatient hospital or surgery center setting, benefits begin on the first day of disability due to either illness or accident. (See separate attachment for waiting period due to COVID-19 Pandemic)

Q: Can I collect Workers Compensation and receive disability benefits through the Trust at the same time?
A: No- Please contact the Trust office for further details.

Q: If my disability is due to a motor vehicle accident, can I receive disability benefits through the Trust at the same time?
A: No- Please contact the Trust office for further details.

Q: Is pregnancy a covered diagnosis?
A: Yes- for female members only.

Q: Do I have to be eligible at the time I am taken off of work?
A: Yes – You must have eligibility on the day you were taken off by your physician.

Q: Can I have my check direct deposited?
A: No- The check will be sent to your home address.

Q: What happens to my insurance when I am not working?
A: If you are receiving weekly disability benefits through the Trust, your dollar bank is frozen once you are off for 30 consecutive days.

Q: When can I expect to receive weekly disability benefit checks?
A: Weekly disability checks are processed and mailed weekly via United State Postal Service (USPS) Priority First Class. Participants should allow 7-10 business days when expecting their check. Replacement checks can be issued upon request if you have not received your check within the 10 business days allowed.

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Most Common Reasons Weekly Disability Claims are Delayed

- Member not signing or dating the form
- Physician did not clarify the dates of disability (the date taken off of work and estimated return to work date)
- Dates of disability are conflicting with your last date worked
- Disability benefits cannot be considered in advance; forms are to be submitted at the time of disability

Weekly Disability Benefit

Weekly Disability Benefit (Employees Only)
Weekly disability benefits are provided if you become disabled and are unable to work as a result of an illness or injury. Benefits are available only for Participating Employees. Associate IIs (Owners) are not eligible for weekly disability benefits.

Benefits: You may be entitled to a weekly disability benefit for any one period of disability of:

- $730 per week for the first 26 weeks; or
- $585 per week for the 27th week through the 52nd week.

The maximum length of time that weekly disability benefits will be paid is 52 weeks.

When Weekly Disability Benefits Begin: Benefits begin on the first day of disability due to an accident and the eighth day of disability due to an illness. However, if you are confined as an inpatient in a hospital or have surgery in an outpatient hospital or surgery center setting, benefits begin on the first day for disability due to either illness or accident. (See separate attachment for waiting period due to COVID-19 Pandemic)

Definition of Disability: For weekly disability benefits, disability or disabled means you are unable to work for pay, profit, or gain at a job for which you are suited by your education, training or experience, and unable to engage in your regular and usual activities.

Successive Periods of Disability: Successive periods of disability separated by less than two weeks of continuous, active, full-time work will be considered one period of disability unless the subsequent period of disability is due to entirely unrelated causes and begins after you have returned to active full-time work for at least one full day.

Taxes: Your weekly disability benefit payment is subject to both FICA (Social Security) and FIT (Federal Income Tax) taxes. The Plan will withhold the appropriate FICA taxes from your weekly check. You have the option of having the Plan withhold federal income taxes from your weekly disability benefit check. The Plan will send you a W-2 at year end so you will be able to file your federal income taxes.

Income from Other Sources: Your weekly disability benefits are reduced if you are receiving other compensation for the same injury or illness. This includes payments received under a Workers' Compensation, occupational disease or state temporary disability law, personal injury protection payments or under an automobile insurance policy. In such situations, the Plan will pay the difference between its normal weekly disability benefit and the amount received from other sources for the same injury or illness.

Filing Claims: Claim forms for weekly disability benefits are available from the Trust office and one is contained in this packet. You must notify the Trust Office, in writing, within 60 days of the date you become disabled.

If you are suffering from permanent total disability, you may be eligible for a disability pension benefit. You are not eligible to receive weekly disability benefits and disability pension benefits at the same time. Contact the Trust Office for additional information. To receive a disability pension benefit, you must apply to the U.A. Union Local No. 290 Pension Trust.

Exclusions: Weekly disability benefits will not be provided in the following situations:

- You fail to file a timely or complete application or do not provide the documentation necessary to establish your disability;
- Your disability is the result of an illness or injury for which a third-party is legally liable or potentially liable. If you comply with the third-party liability provisions of the Plan, the Trust will advance up to ten (10) weeks of disability benefits subject to reduction to reflect any income from other sources;
- Your disability is the result of an illness or injury for which you have a claim under a Workers Compensation, occupational disease or related law. If you comply with the third-party liability provisions of this Plan, the Trust will advance up to ten (10) weeks of disability benefits subject to a reduction to reflect any income from other sources;
- Your disability is not certified by an Eligible Provider or for which you are not under the care of an Eligible Provider;
- Your disability is the result of a surgery or other Medically Necessary services or is excluded under the terms of the Plan;
- If you are receiving Pension benefits from the U.A. Union Local No. 290 Plumber, Steamfitter and Shipfitter Industry Pension Trust for the same time period.

Return this form to:

UA 290 PLUMBER, STEAMFITTER & SHIPFITTER INDUSTRY HEALTH TRUST
12205 SW TUALATIN RD, SUITE 200
TUALATIN, OR 97062
T: 866-796-2305 F: 971-239-0671

STATEMENT OF DISABILITY CLAIM

DO NOT ATTACH MEDICAL BILLS

(TO BE COMPLETED BY EMPLOYEE)

PART 1 INSURED MEMBER COMPLETES

EMPLOYEE'S NAME (LAST) (FIRST) (INITIAL)

EMPLOYER NAME (OR COMPANY YOU WORK FOR)

ADDRESS

DATE EMPLOYED

EMPLOYEE'S DATE OF BIRTH

SEX ☐ M ☐ F

CITY, STATE

ZIP CODE

SOCIAL SECURITY NO.

LOCAL UNION NO.

HOME TELEPHONE NO.

NAME AND ADDRESS OF ANY OTHER INSURANCE CARRIER OR ORGANIZATION PROVIDING BENEFITS FOR THIS CLAIM (INCLUDING AUTOMOBILE INSURANCE AND WORKMENS COMPENSATION)

OCCUPATION

DID PATIENT'S WORK CAUSE THIS CONDITION? ☐ YES ☐ NO

HAS A CLAIM BEEN FILED WITH THE WORKMEN'S COMPENSATION CARRIER? ☐ YES ☐ NO

FIRST DAY UNABLE TO WORK DATE HOUR ☐ A.M. ☐ P.M.

IF YOU HAVE RETURNED TO WORK, GIVE DATE OF RETURN:

IF CLAIM IS FOR AN INJURY, COMPLETE THIS SECTION

DATE OF INJURY

TIME ☐ A.M. ☐ P.M.

WAS PATIENT AT WORK WHEN INJURED? ☐ YES ☐ NO

IF YES, FOR WHOM?

HOW DID INJURY HAPPEN?

WHERE WAS THE PATIENT WHEN INJURED?

FIRST DAY UNABLE TO WORK: DATE: HOUR: ☐ A.M. ☐ P.M.

* I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE ANY PERSON OR INSTITUTION PROVIDING CARE OR SERVICES, OR ANY ORGANIZATION IN POSESSION OF INSURANCE OR BENEFIT INFORMATION TO RELEASE ANY AND ALL INFORMATION PERTAINING TO THE CARE OR BENEFITS PROVIDED TO ME OR MY DEPENDENTS.

EMPLOYEE SIGNATURE
X

DATE SIGNED

PART 2 ATTENDING PHYSICIAN STATEMENT

PHYSICIAN'S STATEMENT OF DISABILITY

1. PATIENT'S NAME

AGE

ADDRESS

2. DIAGNOSIS AND CONCURRENT CONDITIONS (OR I.C.D.A.)

NATURE OF SURGICAL OR OBSTETICAL PROCEDURE, IF ANY (DESCRIBE FULLY)

3. IS CONDITION DUE TO INJURY OR ILLNESS ARISING OUT OF EMLOYMENT? ☐ YES ☐ NO

4. IS CONDITION DUE TO PREGNANCY? ☐ YES ☐ NO

APPROX. DATE OF DELIVERY

5. HAS CLAIMANT FILED WITH A WORKER'S COMPENSATION CARRIER? IF YES, PLEASE IDENTIFY: ☐ YES ☐ NO

6. GIVE DATES OF TREATEMENTS

OFFICE

HOME

HOSPITAL (ADMISSION) (DISCHARGE)

7. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO

8. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED:

9. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION:

10. PATIENT WAS CONTINUOUSLY DISABLED (UNABLE TO WORK)? ☐ YES ☐ NO FROM THROUGH

11. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:

DESCRIBE COMPLICATIONS, IF ANY, PRECLUDING PATIENTFROM RETURN TO REGULAR OCCUPATION

DATE

PRINT OR TYPE PHYSICIAN'S NAME AND DEGREE

SIGNATURE (ATTENDING PHYSICIAN)

STREET ADDRESS

CITY OR TOWN

STATE

ZIP CODE

TELEPHONE

U. A. UNION LOCAL 290 PLUMBER, STEAMFITTER & SHIPFITTER INDUSTRY HEALTH & WELFARE TRUST

12205 SW Tualatin Rd., Suite 200
Tualatin, OR 97062
Phone (503) 486-2104 * (866) 796-2305 * Fax (971) 239-0671
www.zenith-american.com

Request for Update on Disability

On the claim form you submitted, your doctor certified you were disabled through current. We need an actual date of at least your next medical appointment.

If you are still disabled, have your doctor complete the statement below and return it to the Trust Office in the envelope provided.

Further weekly disability benefits cannot be paid unless this statement is fully completed by your physician and returned to us immediately.

Thank you,
Linda Armstrong
ZA-Claims-PDX@zenith-american.com

To be completed by attending physician

1. Date claimant first consulted you for this disability: ___/ ___
2. Is the claimant still disabled and unable to work for any wages or profit? Circle one:
   YES NO
3. Diagnosis and concurrent conditions of claimant:
4. Is this disability due to patient's employment? Circle one: YES NO
5. Claimant ______________________ was /will be continuously disabled and unable to work from:
   ___/___/___ through ___/___/___
6. If still disabled, please indicate the date the claimant should be able to return to work: (To avoid a delay in processing of this claim, please give a specific or approximate return to work date.)

Doctor's Name and Degree: ______________________
Street Address: ______________________
City, State, Zip Code: ______________________

Doctor's Signature: ______________________ Date: __________

Any fee for this information is not chargeable to the Trust

Note: Any person or persons making a willful misrepresentation in completing this form shall be liable to the Trustees for any loss to the fund resulting from such misrepresentation.

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AUTHORIZATION RELEASE FORM

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PERSON WHOSE PROTECTED HEALTH INFORMATION WILL BE DISCLOSED

Name: ______________________ **Birthday:** ___/___/___

Address: ______________________ **Home Telephone No:** ______________________

______________________ **Work Telephone No:** ______________________

______________________ **E-mail Address:** ______________________

Covered Employee's Social Security Number: ______________________

PURPOSE OF AUTHORIZATION

This Authorization is required for the Trust to release your health information to someone other than yourself or for purposes outside the Trust's normal operations (treatment, payment of claims or healthcare operations). The recipients of this Authorization will rely on it to disclose your health information. Please review it carefully.

NATURE OF DISCLOSURE BEING AUTHORIZED The information requested in Questions 1 through 7 must be provided for this Authorization to be effective.

1. Describe information to be disclosed: Identify here what you authorize to be used or disclosed. The information should be specific such as "Information related to my knee surgery". List information here: ______________________

____

____

Describe the purpose of the disclosure: List why the information is being disclosed. If you are initiating the request you can simply check here: ☐ At the request of the individual. Otherwise, list the purpose: ______________________

____

2. **Identify who is authorized to disclose the information:** Identify here who is authorized to make the disclosure.
   - ☐ All entities with information about the matters listed in paragraph 1
   - ☐ Only the following entities: ______________________

3. **Identify who will receive the information:** List here who is authorized to receive information such as "Mary Jones", my spouse or "John Doe, my union representative."

   ____

4. **Identify how to provide information:** Where and how should the information be disclosed? Lisa address, email, facsimile, etc. Please remember that the information being sent is your private health information. ______________________

   ____

5. **Expiration date of Authorization:** Indicate when your authorization will end. This can be a date (December 21,2004") or the **happening of an event ("when my appeal is resolved"). Unless otherwise indicated, this authorization will be good for one year.**
   - a. ☐ For one year from the date of the authorization.
   - b. ☐ Until Date ___/___/___
   - c. ☐ Upon the occurrence of the following event: ______________________

6. **Signature and Date: Important – This document must be signed and dated.**

   Signature: ______________________ Date: ______________________

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STATEMENT OF RIGHTS REGARDING THIS AUTHORIZATION

General Rights. I Understand I am not required to sign this form and that Covered Entity receiving it cannot condition treatment, payment or eligibility on my decision to sign this form. I understand, however, that a health plan can condition enrollment in the Plan or eligibility for benefits on receiving an authorization if the purpose is to allow the health plan to obtain information it needs to make an eligibility, enrollment or underwriting decision and psychotherapy notes are not requested.

Right to Revote. I understand that I have the right to revoke this authorization in writing except as to uses and or disclosures already made in reliance on it. Authorization revocation forms can be obtained by contacting the Privacy Contact Person listed in the Trust's Privacy Notice.

Effect of Disclosure. I understand that if the persons to whom my health information is disclosed are not subject to the HIPAA Privacy Rule (i.e., are not a health plan, health care provider or health care clearinghouse), the disclosed health information may no longer be protected by the HIPAA Privacy Rule and may be redisclosed without my authorization.

Retention and Right to Copy. I understand that the Trust must retain a copy of this Authorization and provide me a copy.

Provisions Related to Psychotherapy Notes. I understand that an Authorization is required for any use or disclosure of psychotherapy notes as defined in 45 CFR 164.508(a)(2) except in the limited situations dealing with treatment, training or defense of legal actions.

PERSONAL REPRESENTATIVE:
This section only needs to be answered if this authorization is being completed by someone other than the individual to whom the health information relates.

If this Authorization is being completed by someone as a personal representative of the individual to whom the health information relates, this section must be completed and signed.

The Trust, for purposed of the Privacy Rule will treat a properly designated personal representative as the individual for purposed of the Privacy Rule. This will apply when the individual is deceased, the personal representative has been designated in accordance with applicable law, or in the case of unemancipated minors, an authorization is required as a result of state law. The Trust reserves the right to decline to recognize an individual as a personal representative if there is a reasonable belied that the individual whose information would be disclosed has been or could be subject to abuse, neglect or endangerment by disclosure. Disclosure also will not be made if inconsistent with applicable law.

Except as limited by state law or the Privacy Rules, no authorization is needed to disclose information to a natural parent or legal guardian of an unemancipated minor. A statement concerning disclosure of information regarding minors is available from the Contact Person listed in the Trust's Privacy Notice.

a. Name of Personal Representative:
b. Basis for Being Personal Representative (e.g. guardian, executed health care power of attorney, etc.) Identify basis or attach a copy of any document creating your authority to act for the named individual.

Address: ______________________ **Telephone No.:** ______________________

E-mail Address: ______________________ ______________________

Signature: ______________________ **Date:** ______________________

UA Local 290 Plumber, Steamfitter & Shipfitter Industry
Health & Welfare Trust
12205 SW Tualatin Road, Suite 200
Tualatin, Oregon 97062
(503) 486-2104 or (866) 796-2305
FAX: (971) 239-0671

SPECIAL INSTRUCTIONS FOR WEEKLY DISABILITY BENEFITS DUE TO COVID-19 OR EXPOSURE

Dear Member,

If you have been diagnosed with COVID-19, tested positive for COVID-19 or need to quarantine due to COVID-19 exposure, please review the following to file for weekly disability benefits under the UA Local 290 Plumber, Steamfitter & Shipfitter Industry Health & Welfare Trust.

Attached is a COVID-19 Statement of Disability Claim Form. As the Employee, please complete the upper portion of the form completely.

If you have been diagnosed with COVID-19 by a physician, your physician will need to complete the Physician's Statement of Disability portion of the form and return the form to the Trust Office at the address or fax number above.

If you have tested positive for COVID-19 or need to quarantine due to COVID-19 exposure, your Employer will need to complete the Employer's Certification of Disability portion at the bottom of the form. The form can then be returned to the Trust Office at the address or fax number above.

Weekly disability benefits for COVID-19 when diagnosed by a physician, testing positive for COVID-19 or due to exposure to COVID-19 and required to quarantine are payable on the first day of disability.

If you have any questions, please contact the Trust Office, where a Claims Representative will be happy to assist you.

Thank you,

Claims Department
(503) 486-2104
ZA-Claims-PDX@zenith-american.com

Return this form to:

UA 290 PLUMBER, STEAMFITTER & SHIPFITTER INDUSTRY HEALTH TRUST

12205 SW TUALATIN RD, SUITE 200 TUALATIN, OR 97062

T: 866-796-2305 F: 971-239-0671

COVID -19 STATEMENT OF DISABILITY CLAIM

PART 1 MEMBER COMPLETES

EMPLOYEE'S NAME (LAST) (FIRST) (INITIAL)			EMPLOYER NAME (OR COMPANY YOU WORK FOR)	
ADDRESS			DATE EMPLOYED	DATE OF BIRTH: SEX: ☐ M ☐ F
CITY, STATE	ZIP CODE		SOCIAL SECURITY NO.	HOME TELEPHONE NO.
NAME AND ADDRESS OF ANY OTHER INSURANCE CARRIER OR ORGANIZATION PROVIDING BENEFITS FOR THIS CLAIM (INCLUDING AUTOMOBILE INSURANCE AND WORKMENS COMPENSATION)			OCCUPATION	
WAS PATIENT EXPOSED TO COVID AT WORK? ☐ YES ☐ NO			FIRST DAY UNABLE TO WORK DUE TO COVID EXPSOURE: DATE HOUR ☐AM ☐PM	IF YOU HAVE RETURNED TO WORK, GIVE DATE OF RETURN:
IF CLAIM IS FOR POSITIVE COVID TEST, PLEASE COMPLETE	DATE OF COVID TEST	PLEASE ATTACH PICTURE OF COVID TEST RESULT		

"I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE ANY PERSON OR INSTITUTION PROVIDING CARE OF SERVICES, OR ANY ORGANIZATION IN POSESSION OF INSURANCE OR BENEFIT INFORMATION, TO RELEASE ANY AND ALL INFORMATION PERTAINING TO THE CARE OR BENEFITS PROVIDED TO ME OR MY DEPENDENTS."

EMPLOYEE'S SIGNATURE: X	DATE SIGNED:

PART 2 PHYSICIAN COMPLETES

PHYSICIAN'S STATEMENT OF DISABILITY IF COVID-19 DIAGNOSED BY PHYSICIAN

1. PATIENT'S NAME:	AGE	ADDRESS

2. DIAGNOSIS AND CONCURRENT CONDITIONS (OR I.C.D.A)

3. IS CONDITION DUE TO COVID-19 EXPOSURE? ☐ YES ☐ NO

4. GIVE DATES OF APPOINTMENTS	OFFICE
	EMERGENCY REOOM
	HOSPITAL (ADMISSION) (DISCHARGE)

5. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?

6. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED:	7. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION?

8. PATIENT WAS CONTINUOUSLY DISABLED (UNABLE TO WORK): ☐ YES ☐ NO FROM THROUGH

DESCRIBE COMPLICATIONS, IF ANY, PRECLUDING PATIENT FROM RETURN TO REGULAR OCCUPATION: ____________________

DATE	PRINT OR TYPE PHYSICIAN'S NAME AND DEGREE	SIGNATURE (ATTENDING PHYSICIAN)	
STREET ADDRESS	CITY OR TOWN & STATE	ZIP CODE	TELEPHONE NO.

IF QUARANTINED DUE TO EXPOSURE AT WORKSITE, PLEASE HAVE EMPLOYER OR DISPATCH COMPLETE FOLLOWING:

EMPLOYER STMT

EMPLOYER OR DISPATCH MUST CERTIFY FOR DISABILITY

DATE EMPLOYED:	HOURLY WAGE:	FIRST FULL DAY UNABLE TO WORK:	DATE RESUMED WORK:	DATE EXPECTED TO RESUME WORK:

Company Name: ____________________ Dispatch Certification: ☐ YES ☐ NO

Mailing Address: ____________________ Telephone: ____________________

STREET CITY STATE ZIP (AREA CODE) NUMBER

IS THIS DISABILITY THE RESULT OF COVID EXPOSURE ARISING IN THE COURSE OF EMPLOYMENT? ☐ YES ☐ NO Date of Exposure: __________

Dated: __________ By: __________ Title: __________