PACIFIC SERVICE EMPLOYEES AND BENEFITS ASSOCIATION
1390 Willow Pass Road, Suite 240 Concord, CA, 94520
1 (800) 272-7732 or (925) 246-6200

Dear Disability Plan Member:

Enclosed is your Pacific Service Employees Disability Plan Claim Statement. Before incurring any costs, please make certain that you are a current member of the Disability Plan. Please complete the Member's Statement, have your physician complete the Certificate of Attending Physician or Practitioner, and sign and date the Members' Authorization for Release of Informaiton . Use the envelope provided to return these forms to PSEA.

Please read the following information carefully so as to ensure prompt payment of your disability checks.

- **The Disability Plan will pay benefits beginning the eighth calendar day of your disability, with no exceptions. The Plan pays regardless of sick-time or Worker's Compensation payments.**

- **Benefit payments are for a maximum of 25 weeks or until released to return to work by your physician, whichever occurs first. Benefit payments cease even if you return to work part-time or on restricted duty.**

- Pregnancy benefits are paid beginning four weeks prior to estimated delivery date and six weeks after a normal delivery or eight weeks after a cesarean delivery. The exception would be medical complications for the mother, certified by a physician.

- **If claim is not submitted within six (6) months after you become eligible for benefits, please include a brief letter of explanation as to the reason for the late filing.**

- **It is member responsibility to complete the member portion of the Claim Statement and have his/her physician complete the Certificate of Attending Physician portion.** Mail the original completed claim statement to PSEA (address is on the claim statement), and keep a copy for your records. **Be sure there are no alterations and all questions are answered. The physician's personal signature is required on all claim forms.**

- **Your claim cannot be initiated without receipt of the MEMBER'S SIGNED AND DATED AUTHORIZATION FOR RELEASE OF INFORMATION. DO NOT FORWARD THIS FORM TO YOUR PAYROLL CLERK. PLEASE MAIL IT BACK TO PSEA.**

- **PLEASE BE ADVISED THAT YOUR FIRST CHECK MAY NOT BE FOR A FULL PAYMENT PERIOD. CHECKS ARE GENERATED 8 DAYS AFTER THE PAID THROUGH DATE SO IN ORDER TO PROCESS YOUR CLAIM QUICKLY AND EXPEDITE FUTURE PAYMENTS, YOUR FIRST CHECK MAY BE FOR LESS THAN 14 DAYS.**

For information call the PSEA Benefits Department at 925-246-6289.

PACIFIC SERVICE EMPLOYEES DISABILITY PLAN
CLAIM STATEMENT

INSTRUCTIONS TO MEMBER FOR FILING CLAIM

- Submit this claim form if you are a member of Pacific Service Employees Disability Plan and are disabled. Eligibility begins on the eighth calendar day after you are disabled, even if you are receiving sick leave from the Company. It is your responsibility to see that this form is completed and submitted within six (6) months after you become eligible for benefits. Answer all questions under the heading "Member's Statement", have your Physician or Practitioner fill in the reverse side of this form, then forward it to the PSEA Office at: PSEA, Benefits Department, 1390 Willow Pass Road, Suite 240, Concord CA 94520.
- To be eligible for benefits you must be under the care of a physician, surgeon, optometrist, dentist, osteopath, chiropractor, chiropodist, qualified licensed nurse practitioner or nurse-midwife (limited to certifying normal pregnancy and childbirth related disabilities only), government medical officer or an authorized and accredited practitioner. Claims completed by a non-physician (e.g. marriage, family or child counselor; licensed clinical social worker) are not covered by the PSEA Disability Plan.

MEMBER'S STATEMENT

1. Full Name (print or type)_____ Home Phone # ( )_____

2. Mailing Address_____
(Number) (Street) (City) (Zip)

3. Last 4 digits of SSN_____ Year of Birth_____Sex: Male ☐ Female ☐

4. Home email: _____ Your LAN ID: _____

5. Supervisor: _____Telephone:_____Lan ID:_____

   Address:_____ _____ _____ _____
   Number Street City State Zip Code

6. When did you first become disabled? On_____, 20_____

7. Was your injury work related? Yes ☐ No ☐
   If "yes" are you receiving Worker's Compensation? Yes ☐ No ☐

8. What is the nature of illness or injury?_____

   _____

9. Have you returned to work? Yes ☐ No ☐ If so, when?_____, 20_____

10. If you are still disabled, when do you expect to return to work?_____, 20 _____

I certify that the above statement is, to the best of my knowledge and belief, true, correct and complete. I hereby authorize my attending physician, practitioner, hospital and employer to furnish and disclose all facts concerning my disability that are within their knowledge and to allow inspection of and provide copies of any hospital records concerning my disability that are under their control. I understand this authorization is granted for a period of 18 months from the date of my signature or the effective date of the claim, whichever is later. I agree that a photocopy of this release shall be valid as the original.

Date_____ Signature _____

Return completed form to: **PSEA Benefits Department**
1390 Willow Pass Road, Suite 240
Concord, CA 94520

PSEA DISABILITY PLAN
CERTIFICATE OF ATTENDING PHYSICIAN OR PRACTITIONER

1. Full name of claimant _____

2. I attended to patient for the present medical problem from: Month Day Year _____ To Month Day Year _____

   At intervals of: _____

3. Describe nature of illness or injury_____

   _____

4. Diagnosis: _____

5. Has the patient at anytime during your attendance for this medical problem, been incapable of performing their assigned, regular or customary work? Yes ☐ No ☐ If "Yes", the disability commenced on:_____ (MO/DAY/YR)

6. APPROXIMATE date, based on your examination of the patient, disability should end or has ended sufficiently to permit the patient to resume regular or customary work. _____ (MO/DAY/YR)

   (Even if considerable question exists, make SOME "estimate". If such date is not entered, the claim cannot be processed. Such answers as "indefinite" or "don't know" will not suffice.)

7. Based on your examination of the patient, is this disability the result of "occupational" either as an "industrial accident" or as an "occupational disease"? Yes ☐ No ☐

8. If applicable, is pregnancy normal? Yes ☐ No ☐ If "No", state the abnormal and involuntary complication causing maternal disability: _____

   Estimated Date of Delivery: _____

9. If applicable, was or is this patient a resident in an alcoholic recovery home or a drug-free residential facility? Yes ☐ No ☐ If "Yes", please provide name and address: _____

10. Was or is patient confined as a registered bed patient in a hospital? Yes ☐ No ☐ If "Yes", please provide name and address: _____

11. Date and hour entered as a registered bed patient and discharged pursuant to your orders:

ENTERED	STILL CONFINED	DISCHARGED
on , 20 , at A.M. P.M.	on , 20 , at A.M. P.M.	on , 20 , at A.M. P.M.

I hereby certify that, based on my examination, the above statements truly describe the patient's disability and the estimated duration thereof, and that I am a _____ licensed to practice by the State of _____
(TYPE OF DOCTOR)

⇒ _____
PRINT OR TYPE DOCTOR'S NAME AS SHOWN ON LICENSE

⇒ _____
SIGNATURE OF ATTENDING DOCTOR
(No rubber stamp signatures allowed)

⇒ _____
NO. AND STREET CITY ZIP

⇒ _____ _____
STATE LICENSE AREA CODE, PHONE DATE OF SIGNATURE

PSEA DISABILITY PLAN

MEMBER'S AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize my employer to furnish and disclose all facts concerning my disability that are within their knowledge and to allow inspection of and provide copies of any records concerning my disability that are under their control. I understand that this authorization is granted for a period of eighteen (18) months from the date of my signature or the effective date of the claim, whichever is later. I agree that a photocopy of this release shall be valid as the original.

I understand the Plan Sponsor will use the information obtained under this Authorization to determine eligibility for insurance benefits. Any information obtained will not be released to any person or organizations except to the Plan Sponsor.

If I receive a disability benefit greater than that which I should have been paid, I understand that the Plan Sponsor has the right to recover such overpayment from me, including the right to reduce future disability benefits, if any.

I understand that any person who knowingly and with intent to injure, defraud, or deceive the Plan Sponsor, files a statement or claim containing any false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Date _____ Signature _____

LAN ID _____ Print Name_____

DO NOT GIVE THIS FORM TO YOUR SUPERVISOR! IT WILL BECOME VOID IF NOT RETURNED DIRECTLY TO PSEA FOR FORWARDING TO PG&E

TO BE COMPLETED BY EMPLOYER AT INCEPTION OF CLAIM

Date Employee Last Worked	Date Employee Expected to Return to Work

Is condition due to an occupational cause?
☐Yes ☐ No ☐Undetermined

Printed Name of Supervisor	Lan ID of Supervisor
Signature of Supervisor	Date Signed

TO BE COMPLETED BY EMPLOYER AT END OF CLAIM

Date Employee Returned to Work	If Worker's Comp Claim, please indicate status: ☐ Accepted ☐ Pending ☐ Denied ☐ Not Filed

Printed Name of Supervisor	LAN ID of Supervisor
Signature of Supervisor	Date Signed