ILWU-PMA WELFARE PLAN
Supplemental CSDI Disability Claim Form

PART 1 – EMPLOYEE STATEMENT

Fill out and attach your CSDI Check Stub(s)

1. Name:	2. Local Number:	3. Registration Number:	4. Social Security Number:

5. Address (Street, City, State & Zip Code):	6. Telephone Number:

7. On what date did you last work before your disability began?	8. Has your disability ended? YES ☐ NO ☐	9. **IF YES TO #8** – provide the date you were released to return to work:

10. Is your disability due to an accident? YES ☐ NO ☐	11. ***IF YES TO #10*** – Where did the accident happen and how?
IF YES – *provide the date:* _____	12. Is there a liable third party? YES ☐ NO ☐ ***IF YES to #12*** – *Include a completed Agreement to Reimburse Benefits form*

Federal or State Workers' Compensation Information

13. Is your disability due to an accident, injury or illness arising out of employment? YES ☐ NO ☐	14. ***If YES to #13*** –You ***MUST*** file a claim for Federal or State Workers' Compensation Benefits. The Welfare Plan will not provide benefits related to an industrial disability unless workers' compensation benefits are denied. Have you filed or do you intend to file a claim under and Federal or State Workers' Compensation Law? YES ☐ NO ☐
IF NO – *proceed to #15*	***IF YES*** – *Include a completed Agreement to Reimburse Benefits form* ***and*** *documentation workers' compensation denial*

15. The above answers are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution, druggist, insurance company, employer, labor union, or association to release information to ILWU-PMA COASTWISE CLAIMS OFFICE as required to properly pay all benefits, if any due me for this claim:

Employee Signature: _____ Date: _____

Please mail completed form and documentation to:

ILWU-PMA Coastwise Claims Office
P.O. Box 429101
San Francisco, CA 94142
Tel: (415) 919-5828
Fax: (415) 801-4092

PART 2 – FOR OFFICE USE ONLY

Date of Birth:	Social Security Number:
Eligible: YES ☐ NO ☐	End Date:
Status: ACTIVE ☐ RETIRED ☐ DISABILITY ☐ NORMAL ☐	End Date:
Transmitted by:	Date: