Short-Term Disability Benefits - COVID-19 Disability Application

St. Louis – Kansas City Carpenters Regional Health Plan (Plan)
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CARPENTERS BENEFIT PLANS
HEALTH & RETIREMENT SERVICES

I. Participant Information (please print or type)

Last Name	First Name	Middle Initial	Date of Birth	Last 4 SSN

Street Address	City	State	Zip Code

Mobile Phone	Email Address

Last/Current Employer	Last Day of Work

Unemployment/Wage & Benefits Certification

☐ **In order to qualify for this benefit, I confirm I have not applied for/currently receiving Unemployment benefits nor am I receiving wages or short-term disability benefits from my employer.**

II. Participant Certification due to COVID-19 (to be completed by member)

Please complete ONLY ONE of the following that apply to you based upon your health-related circumstances due to COVID-19.

1. **Quarantine Due to Exposure/Possible Exposure to COVID-19**
   - ☐ I am in quarantine (mandated or self-quarantine) due to exposure
   - ☐ An individual (with whom I reside) is in quarantine due to exposure

   Explain exposure (who and where):_____

   Dates of Quarantine FROM: _____ THROUGH: _____

2. **Positive or Assumed Positive Due to Symptoms**
   - ☐ I have been placed in quarantine by a medical professional or have tested positive for COVID-19. **A statement from a medical professional (physician or Public Health Official) IS REQUIRED. The medical professional may complete Section III of this form or supply a letter on their letterhead.**
   - ☐ An individual (with whom I reside) has been placed in quarantine due to symptoms of, or has tested positive for, COVID-19. **A copy of a letter from the physician indicating the positive result or quarantine due to symptoms of COVID-19 provided to the individual is sufficient.**

     Individual's Name: _____ Relationship: _____

III. Physician Statement (to be Completed by Physician or Public Health Official)

PHYSICIAN INSTRUCTIONS: The information request below is required to determine eligibility for weekly accident and sickness benefits due to COVID-19. Please complete this section in its entirety.

1. Date Patient first consulted you for this condition: _____
2. Did above patient test positive or is assumed positive: Yes/No If no, please explain reason for quarantine below:

   _____
3. Specific dates of Total Disability or Quarantine FROM: _____ THROUGH: _____

Signature of Physician/Medical Professional, Title	Date	Federal EIN/SSN	Print Physician/Medical Professional Name & Phone

IV. Signature and Certification of Participant

I hereby certify the foregoing statements, including any accompanying statements are true, correct and complete to the best of my knowledge and hereby authorize my employer and/or medical professional (whichever may apply) to furnish and disclose all facts for the purpose of determining my eligibility for the requested benefits(s).

Member Signature	Date