Ullico
SOLUTIONS FOR THE UNION WORKPLACE

NOTICE OF CLAIM FOR SHORT TERM DISABILITY BENEFITS

PLEASE PRINT

Please submit this form to:
The Union Labor Life Insurance Company
Claim Service Center
1500 Main Street, Suite 1400, PO Box 15309
Springfield, MA 01115-5189
Toll free: (888) 855-4261 • Fax: (860) 769-6986

AS REQUIRED BY LAW, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND MAY ALSO BE SUBJECT TO CIVIL PENALTIES FOR EACH SUCH VIOLATION.

EMPLOYEE'S STATEMENT (All questions must be answered to avoid delay)

Name of employee:	SSN:		☐ Male ☐ Female
Address:	City:	State:	Zip:
Phone:	Date of birth:		
Date accident or sickness began:	Date last worked:	Date first treated:	
Nature of sickness or injury:	Did accident happen at work?	☐ Yes ☐ No	
If injured, how and where did accident happen?			
Name of physician first consulted for this condition:			
Address:	City:	State:	Zip:
Name of family physician:			
Address:	City:	State:	Zip:
If confined, name of hospital:			
Address:	City:	State:	Zip:
Dates of inpatient confinement In:	Out:		

Check benefits you receive from any of the following for this disability, and list the name, policy number, address and phone number of insurance company or organization providing such benefits or services:

☐ None ☐ Association Membership ☐ Workers' Compensation ☐ Salary Continuance ☐ Social Security
☐ No Fault ☐ Any Government Agency ☐ Public or Private Retirement Benefit ☐ Other _____

Name of insurance company or organization:			
Policy number:	Phone:		
Address:	City:	State:	Zip:
Name of insurance company or organization:			
Policy number:	Phone:		
Address:	City:	State:	Zip:

I request voluntary Federal Tax Withholding ☐ Yes ☐ No
If "Yes," indicate the amount to be withheld from weekly benefits. $_____ (20% minimum withholding).
I CERTIFY THAT THE STATEMENTS IN THIS SECTION ARE TRUE AND COMPLETE.

Signature of employee: Date:
X

THIS SECTION TO BE COMPLETED BY POLICYHOLDER

Policy number:	Effective date:	Termination date:

I certify that the member named in this claim was eligible for disability benefits during the period specified above.

Policyholder's representative: X Title: Date: