SUPPLEMENTARY DISABILITY/WORKER'S COMPENSATION BENEFIT CLAIM FORM

Office and Professional Employees International Union, Florida Nurses Association LOCAL 713, AFL-CIO
P.O. Box 536985, Orlando, Florida 32853
Phone: 407-896-3261 Fax: 407-896-9042

LENGTH OF DISABILITY MUST BE AT LEAST SIX (6) CONSECUTIVE WEEKS

To be eligible for this Local 713 benefit, you must:

1. **Have been a member in good standing for 12 consecutive months or more.**
2. **Be current with the payment of dues while on Disability or Workers' Compensation. (IF DUES ARE NOT BEING DEDUCTED FROM YOUR CHECK, YOU ARE RESPONSIBLE FOR MAKING PAYMENTS BY PERSONAL CHECK OR MONEY ORDER.)**
3. **Attach a copy of Worker's Compensation Form or Disability Form. This form must include all of the following:**

   a) **doctor's signature.**

   b) **specific dates (the calendar date you were first unable to work, and the calendar date you were able to return to work).**

   c) **Completion of Employer's Statement.**

Note: *This benefit must be claimed (RECEIVED IN OUR OFFICE) by the end of the year following the year the disability first occurred. *Please be aware of the time your claim may take to arrive by mail.*

IF SENDING IN DUES PAYMENT PLEASE WRITE ON FACE OF CHECK/ MONEY ORDER & ENVELOPE "Supplementary Disability Benefit".

MEMBER INFORMATION

1. NAME_____ 2. SS#_____

3. ADDRESS_____
   No./Street Apt. # City State Zip Code

4. EMPLOYER_____

5. TELEPHONE NO: Home ( )_____ Work ( )_____

Date Disability Began_____ **Date of Return to Work**_____

Members Signature_____**Date**_____

PLEASE ALLOW A MINIMUM OF 10-12 WEEKS FOR PROCESSING

(For office use only) Membership Record: Initiation Date _____

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afl-cio
3/1/2014

Checked by: _____