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: 407-487-2230 Fax: 407-887-0692

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: _____