IBEW LOCAL UNION NO. 269
SUPPLEMENTAL BENEFIT FUND

c/o I. E. Shaffer & Co.
PO Box 1028, West Trenton, NJ 08628 ♦ 1-800-792-3666 ♦ 1-609-530-1331 (fax)

Application for Supplemental Sick Benefit (SSB)

This form should be completed by the Applicant and Physician immediately after the commencement of disability and sent to the I.E. Shaffer & Co. at the address above for processing.

APPLICANT'S STATEMENT

Name of Applicant _____ Date of Birth _____

Social Security # _____

Street Address _____

City, State, Zip _____ Telephone (___)_____

Date Accident Occurred or Sickness Began _____

Date Last Worked _____

On What Date Did You or Do You Expect To Resume Work?_____

Applicants Signature_____ Date _____

PHYSICIAN'S STATEMENT

Patient's Name _____ Age _____

Nature of Sickness or Injury _____

_____

Did This Sickness or Injury Arise Out of Patient's Employment? _____

If Yes, Explain _____

Is This Disability Due to Pregnancy? _____

Nature of Surgical or Obstetrical Procedure, If Any (Describe Fully) _____

_____

Date Performed _____

Give Dates of Treatment

Office _____

Home _____

Hospital _____

The Patient Has Been Continuously Disabled (unable to work) From _____ Through _____

If Still Disabled, When Should Patient Be Able To Return To Work? _____

Restrictions: _____

Remarks: _____

_____

_____

Name of Physician _____ Telephone (_____) _____

Street Address _____

City, State, Zip _____

Date _____ Physician's Signature _____