PENSION, HOSPITALIZATION AND BENEFIT PLAN -WELFARE TRUST FUND
158-11 HARRY VAN ARSDALE JR. AVENUE, FLUSHING NY 11365
PHONE: 718-591-2000 EXT 1350

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APPLICATION FOR WAGE REPLACEMENT BENEFIT FOR PHYSICAL EXAM IF PROVIDED FOR UNDER YOUR COLLECTIVE BARGAINING AGREEMENT

PLEASE PRINT

NAME _____ _____
First Last

ADDRESS _____ Participant ID_____
Number and Street

_____ PHONE # _____
Town or City

_____ DIV. _____UNION CARD # _____
State Zip Code

Please answer below:

1. I am applying for:

   ☐ Medical Exam Day Benefit: (**Maximum of 1 day per calendar year)**
   Please **attach documentation** from **physician and paystub.**

2. Date of physical exam: _____

3. Hourly contractual rate: _____

4. Name of employer: _____

5. Signature of employer: _____

Payment will be made from the Pension, Hospitalization and Benefit Plan –Welfare Trust Fund subject to applicable IRS tax regulation. A Form 1099 will be issued for the calendar year in which the benefit was utilized. The benefit will be paid at a rate equal to the participant's straight time contractual rate, based on the applicable Collective Bargaining Agreement.

Participant's Signature: _____ Date: _____