

**OPEIU Midwest United Local 2009**  
**Disability Benefits Form**

**Member Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Street Address/Apt. #**

\_\_\_\_\_

**City**

**State**

**Zip code**

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**First Day of Absence** \_\_\_\_\_ **Return to work Date:** \_\_\_\_\_

I certify that I am a member in good standing with OPEIU Midwest United Local 2009 and that the above information is correct and true to the best of my knowledge. I understand that I am entitled to a maximum of \$250.00 for disability per year and that a period of disability or worker's compensation extending from one calendar year to another shall be considered as one period. Benefits under the OPEIU disability benefit are paid according to the following schedule:

|   |          |
|---|----------|
| More than three (3) and less than four (4) weeks: | \$100.00 |
| More than four (4) and less than five (5) weeks:  | \$150.00 |
| More than five (5) and less than six (6) weeks:   | \$200.00 |
| More than six (6) weeks:                          | \$250.00 |

**Member Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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*Bottom half of this form must be completed by an OPEIU Representative*

**The number of weeks the Member was absent from work:** \_\_\_\_\_

**Amount that is entitled to the Member:** \_\_\_\_\_

**Disability Form Approved by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**OPEIU Benefits Coordinator signature**