

WAIVER OF PREMIUM BENEFITS CLAIM FORM

INSTRUCTIONS: To be completed by a representative of the Fund/Policyholder when an employee is eligible for Waiver of Premium due to a disability caused by accident or illness. Please print or type all answers and return to above address.

Employee's Name <hr/> <div style="display: flex; justify-content: space-between;"> Last First </div>	Date of Birth <hr/> <div style="display: flex; justify-content: space-around;"> Month Day Year </div>
Address <hr/> Street <hr/> <div style="display: flex; justify-content: space-between;"> City State Zip </div>	Social Security # <hr/> <div style="display: flex; justify-content: center; align-items: center;"> _____ - _____ - _____ </div>
Reason why employee stopped work <hr/> <hr/> <hr/>	Date last day worked <hr/> <div style="display: flex; justify-content: space-around;"> Month Day Year </div>
Benefit Amount of Insurance _____	

Name of Fund/ Policyholder _____	Policy Number _____
Signature of Representative _____	Date _____