

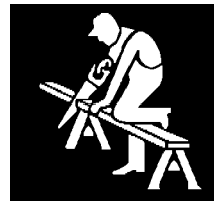
**CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA**

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CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA

To request additional Disability Benefits from this office, a continuation form, along with necessary proof of payment from either State Disability or Workers' Compensation must be submitted. *To avoid delays in processing your request for benefits, please complete the following:*

WEEKLY DISABILITY BENEFIT CONTINUATION FORM

Participant's Name: _____ SSN: _____

Phone Number: _____ Participant I.D.#: _____

Disability effective dates: _____ Claim Number: _____

1. Have you worked at any time since the date of Disability? Yes No
If yes, date(s) worked _____

2. Have you applied for either?: Social Security Disability Yes No
If yes, date applied _____
Carpenters Pension Yes No
If yes, date applied _____

3. Have you been classified as permanently disabled? Yes No If yes, date _____

4. Type of benefit being requested: State Disability (SDI) or Workers' Compensation

In the event that I am granted a Disability Pension retroactively, I authorize the Carpenters Pension Trust Fund for Northern California to deduct from my retroactive Disability Pension Payments and forward the amount owed to the Carpenters Health and Welfare Trust Fund for California.

Participant's Signature _____ Date: _____

Your proof of payment must show the dates of disability.

Claim must be filed within 12 months.

Notice: It is illegal to file a false or fraudulent claim or to knowingly help someone else file one. You may be fined or sent to prison for doing so. You may also be required to pay civil damages.

**ATTACH PROOF OF PAYMENT FROM EITHER STATE DISABILITY OR
WORKERS' COMPENSATION**