SHEET METAL WORKERS LOCAL 292
FRINGE BENEFIT FUNDS
P.O. Box 189
Troy, MI 48099-0189
(248) 641-4992 (888) 646-6565
Fax #-(248) 556-2594
SMW292@subfund.org

APPLICATION FOR WEEKLY DISABILITY SUB BENEFIT

Name: _____

Soc. Sec. No.: _____ Date of Birth: _____

Address: _____

_____

Telephone Number: _____

Name of Employer at the time disability commenced: _____

Non-Occupational Accident and Sickness Weekly Disability Benefit Information:

Last date of work before disability: _____

My disability diagnosis is: _____

Illness: _____

Injury: _____

How did it happen: _____ Where: _____

The Following information is required by the Fund Office for processing your claim:

1. **The above application must be completed.**
2. **The Loss of Time Application for Weekly Disability Benefits. (Orange Form)**

Signature of Applicant: _____ Date: _____