CST BENEFIT FUND

CLAIM NO. _____

2 Crimson Way, Suite 1 • Plattsburgh, N.Y. 12901 • Fax (518) 561-7459

NOTICE OF CLAIM FOR BENEFITS

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

TO BE FULLY COMPLETED BY MEMBER

STATEMENT OF MEMBER: My signature certifies that I am a member and I have been totally unable to work. I furnish the following information which I warrant to be true, complete and correct to the best of my knowledge and belief.

Enter your full name (please print):

Last _____ First _____ Middle _____

Address: _____ _____ _____ _____

No. Street. Apt. No. | City | State | Zip Code

Phone: _____ Soc. Sec. No.: _____

Email: _____

Did you join CST Benefit Fund knowing you were going to be eligible to file a claim for benefits within your first 30 days of membership? _____

My claim is a result of : ☐ Illness ☐ Injury ☐ Workmens Comp. ☐ Other _____

If claim is illness or injury, return doctor's statement also.

MEMORANDUM OF UNDERSTANDING

All members of the Correctional Security Trust (CST) Benefit Fund are governed by the rules, regulations & policies established by the trustees and applicable state and federal laws pertaining to the administration of the trust.

Claims will be received and reviewed by the board of trustees. The board will determine if the claim is actionable or not and notify the member of their decision.

All benefits will be disbursed in accordance with established policy and procedure.

In the event that a member receives or collects any funds, retro pay, back pay, remuneration, stipend, settlement or any monetary fund's arising from the members claim, distributions of money made by the CST Benefit must be returned to the trust.

Signing this memorandum of understanding indicates the member is aware of their rights and obligations and will comply and abide by the rules, regulations and policy of the Correctional Security Trust Fund.

YOU MUST READ, SIGN & RETURN THIS DOCUMENT TO BE CONSIDERED FOR CLAIM PAYMENTS.

_____

PRINT YOUR NAME

_____ _____

MEMBER SIGNATURE DATE

TO BE FULLY COMPLETED BY EMPLOYER

EMPLOYER'S STATEMENT

Name of employee _____

Health Insurance Plan _____ Single ☐ Family ☐

First date employee was unable to work ___ / ___ / ___ Last date employee was physically present at work ___ / ___ / ___

Has employee returned to work? YES ☐ NO ☐ If yes, when ___ / ___ / ___

If no, when is employee expected to return to work? ___ / ___ / ___

Verify up to date leave accruals: VACATION _____ SICK _____ PL _____ Comp Time or Other _____

On what date did or will employee commence leave without pay? ___ / ___ / ___

This is to certify that this is a correct statement from our records on the above named employee.

DATE: ___ / ___ / ___ EMPLOYER: _____

TELEPHONE: _____ BY: _____ TITLE: _____

ADDRESS: _____