COURT OFFICERS BENEVOLENT ASSOCIATION OF NASSAU COUNTY HEALTH AND WELFARE FUND

SUPPLEMENTAL WORKERS' COMPENSATION DISABILITY CLAIM FORM

To submit a Supplemental Workers' Compensation Disability Claim you must:

1. Have been off payroll for 30 days, with your Workers' Compensation claim filed and paid.
2. Complete this form.
3. Attach the benefits statement from Workers' Compensation for the benefit period being claimed.
4. Mail or email completed form and benefit statement to:

COBANC Health & Welfare Fund
1 Old Country Rd.
Ste 282
Carle Place, NY 11514-1845

Email: info@cobanc.org

MEMBER INFORMATION – PLEASE PRINT

Member's Name: _____ Date of Birth: _____

Member's Address: _____
Street

_____
City State Zip Code

¯ Check here if there is a new address. You must notify COBANC prior to submitting this claim.

CLAIM INFORMATION

I became disabled on: _____

I am claiming supplemental benefits for the period from: _____ to _____

For the period of disability covered by the claim:

Are you receiving wages, salary or separation pay? ¯ Yes ¯ No

Are you receiving Workers' Compensation for work-connected disability? ¯ Yes ¯ No

I hereby claim the Supplemental Workers' Compensation Benefit and certify that I was disabled during the period specified above. All statements made and supporting documentation provided are true and complete to the best of my knowledge.

Member's Signature: _____ Date: _____