

Health Accident Fund

The attached form is to be used for the Health and Accident benefits. Upon receipt of proof of accidental bodily injury or sickness, an individual sustains a total disability will pay an income benefit as per the provisions of the Resolution Health and Accident Fund.

Total Disability Defined: As used in the provision, total disability means a disability which wholly and continuously disables the employee so that he/she is unable to perform any duty pertaining to his/her occupation and during which time he/she is not engaged in any other occupation for re numeration or profit. In no event shall total disability be deemed to exist for any period during which the employee is not under the continued and regular care of a licensed physician.

The income shall not begin until the 31st day of disability as specified in the Resolution. The employee must use all sick leave accrued and time of accumulated before payment of this benefit will begin. No further sick-leave will accrue after the activation of this benefit.

Although it is not mandatory under this policy, an employee may elect to utilize their vacation time after their sick leave has been expended. No employee shall receive compensation for any combination of sick leave, vacation, or health and accident benefit simultaneously.

In no case will an employee draw total disability benefits for more than 24 weeks in any calendar year.

No benefit shall be payable for any disability resulting from or contributed to by any of the following: Self-inflicted injury, whether intentional or while insane. War or any fact incident to war being declared or undeclared. Accidental bodily injury arising out of or in the course of the employee's employment. Sickness for which the employee is entitled to benefits under a workman's compensation act or similar legislation.

Amount of weekly payments for employees is \$150.00, but in no case will an employee receive more than 66 2/3% of his/her basic weekly earnings.

(For any additional information, and for a complete copy of the provisions contact Human Resources)



CITY OF FOREST PARK GROUP BENEFITS ACCIDENT AND SICKNESS CLAIM

Full Name Mr. Of Mrs.				Social S	ecurity Nur	mber	Date of Birth		
Claimant Miss									
Address of Claimant									
Street No. City					State Zip				
		Time Date Claimant First Treated AM By Physician For Present Disability					If Recovery Has Occi Give Date	urred,	
	PM Mo. Day Yr.								
First Day Claimant Was Unable to Work Because of Disability		Did Sickness or Injury Arise Out of Claimant's Employment? Yes If Yes, Give Full Details on Reverse Side.							
·	No 🗀								
Mo. Day Yr. Benefit Options Check One (only)									
Block 1 —									
Block 2									
If the Employee wishes to use only Sick Leave check Block No.1 If the Employee wishes to use Sick Leave and Vacation Before Benefit Begins Payments. Check Block No.2									
Date Signature					Department Department				
SUPERVISOR'S STATEMENT									
Full Name Mr.				Classification					
Of Mrs. Insured Miss									
Date Claimant was Hired Date Claimant Began W									
Mo. Day Yr.		Mo. Day	Υ	Yr. Disability Began Yes No					
Was Claimant Laid Off or Lay-Off Completely Prior to Beginning Did the Sickness or Injury arise Out of the Claimants Work?									
of this Disability? Yes No No				Yes No If Yes, state reason on Reverse side why Worker's Compensation is not					
If Yes, Give Date Mo. Day Yr.				payable					
Are There Any Circumstances which would cause you to			_	Average W	-	Amount of Weekly B	f Weekly Benefit		
question the validity of this claim? Yes No If Yes, state reasons on Reverse Side			_	Earnings (F	lours)				
Date Claimant absent from work in present disability?				Cirly Lawre Bollance Verentian Lawre Determined					
Date Claimant absent from work in present disability?				Sick Leave Balance		Vacation Leave Balance	Date work Resumed		
Mo. Day Yr.				No. of Days Mo. Day Yr.			Yr.		
CITY OF FOREST PARK, GA									
DATE: (Signature) DIRECTOR:									
SPACE BELOW FOR ACCOUNTING ONLY									
First Payment Date: Mo. Day Yr.									
Date Charged	narged Check number			Week Ending			Remarks		
	1					1			