



PT/VL Short – Term Disability Benefits (STD) Application

Send to: PT/VL Disability Fund
Faculty and Staff Federation of CCP
1700 Spring Garden St., BR-63
Philadelphia, PA 19130

Contact Information

Name	
CCP Department	
Street Address	
City, State ZIP Code	
Home Phone	
Work Phone	
E-Mail Address	

1. If your disability is the result of illness, state the nature of your disability and the date of your first symptoms:

2. Have you had the same or a related illness before?
No_____ Yes_____ Dates:

3. If your disability is the result of an accident, list the date, time, place, and nature of the accident:

4. List the name and address of the first physician you consulted in connection with this disability and the date of the consultation:

OVER

5. List the name and address of your primary treating physician:

6. List the name and address of the physician who will submit disability documentation (Explain if different than #5 above):

7. List the date you became unable to work as a result of the illness/injury:

8. List the date of your expected return to work:

9. List the date of the last CCP workday for which you received salary *including paid sick days*:

10. List the dates of the specific period for which you are requesting STD benefits:
 From: _____ To: _____

11. Additional remarks:

Agreement and Signature

I hereby declare that the answers given are complete and true to the best of my knowledge. I will not be working or receiving other disability benefits during the period for which I am requesting benefits from the CCP PT/VL Unit. I understand that presenting materially false information or concealing information in order to mislead may result in the denial of funds and/or the demand for the return of funds previously disbursed to me.

Name (printed)	
Signature	
Date	