# WESTCHESTER COBA WELFARE FUND
# SHORT TERM DISABILITY FORM

Name: _____ Date: _____

Address: _____ Phone: _____

_____

Describe your disability: _____

_____

_____

**Please attach medical documents relating to your disability.**

I certify under penalty of perjury:

1. I am an active member of the Westchester County Correction Officers Benevolent association and am currently employed by the County of Westchester.

2. I have incurred a disability that is an original injury or illness and not a reocurrence or aggravation of a prior illness or injury.

3. As a result of this disability, I have exhausted all leave time (i.e. vacation, sick, holiday, half-pay, supplemental, personal).

4. I further certify that, as result of this disability, I was removed from the payroll on ____, which is within the six months prior to the date of this claim.

5. As a result of the disability identified here, I am not receiving other form of salary, income, disability payment or insurance benefits including, but not limited to, social security disability, workers' compensation or GML 207-c benefits, etc.

6. I have not previously received a short term disability benefit from the Welfare Fund.

_____
Signature

Note: Under New York Law, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty.