## Section II

## APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS
## EMPLOYEE'S STATEMENT

**To Be Completed by the Employee (FAILURE TO ANSWER ALL QUESTIONS MAY DELAY YOUR CLAIM)**

### A. Information About You

| Last name | First | Middle Initial | Social Security Number |
|---|---|---|---|
| | | | |
| Address (Street, City, State & Zip.) | | | Your Division/Location |
| | | | |
| Telephone Number<br>(____)_____-_____ | Date of Birth | Gender ☐ Male ☐ Female | Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed |

### B. For an Injury, answer the following questions:

(1) When did the injury occur (date/time)?

(2) Where did the injury occur?

(3) How did the injury occur?

### C. For Illness, Injury or Pregnancy, answer the following questions:

Date you were first treated by a Physician _____

Name of Physician _____ Telephone Number (_____)_____-_____

Address of Physician _____

Before you stopped working, did your condition require you to change your job, or the way you did your job? ☐ Yes ☐ No

If "Yes," explain.

What aspect of your condition made you unable to work?

Are you receiving or eligible for: ☐ Workers' Compensation ☐ State Disability ☐ No Fault Disability ☐ Other

If "Yes," show policy number_____ Name of Insurer _____

Address of Insurer

| Weekly Amount $ | Date Payments Start: | Date Payments Will End: |
|---|---|---|
| | | |

Is your condition related to your occupation? ☐ Yes ☐ No

Have you filed, or do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No If "No," explain:

### D. Information About the Disability

Last day you worked before the disability: _____ Did you work a full day? ☐ Yes ☐ No If "No," explain:

Dates you were first unable to work: _____ Since that date, have you done any work? ☐ Yes ☐ No

If you have not returned to work, do you expect to? ☐ Yes Part time (date)_____ Full time (date)_____ ☐ No

### E. Information About Tax Withholding

**If your request for benefits is approved, the taxable portion of your benefits will be subject to Federal Income Tax Withholding rules. Tax withholding will be based on single status rate with no exemptions. If you wish to have Mohawk use different withholding allowances please attach a fully completed form W-4.**

**F. Employee Signature** (The statements contained in this form are true and complete to the best of my knowledge and belief).

**X** _____ **X** _____

***SIGNATURE OF THE EMPLOYEE*** ***DATE***

## APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS
## EMPLOYEE'S STATEMENT
## DECLARATION AND FRAUD WARNINGS

With the exception of any source(s) of income reported above in Section C of this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period the administrator has approved my disability claim, I must report all details to The Mohawk Benefits Service Center immediately.

If I receive disability income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. Mohawk has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

**For residents of all states *EXCEPT* California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, New York, Virginia, Puerto Rico and District of Columbia:** A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** (In Oregon, a fraudulent insurance act may be a crime.) Mohawk shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

**For residents of Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**For residents of New Jersey, Arkansas, and New Mexico:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**For residents of Pennsylvania:** 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 subjects a person to criminal and civil penalties.

**For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading information to an Insurance Company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.**

**FOR RESIDENTS OF CALIFORNIA: FOR YOUR PROTECTION, CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON."**

**For residents of Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**For residents of New York:** 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 not to exceed five thousand dollars and the stated value of the claim for each such violation.

**For residents of Puerto Rico:** Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

**For residents of Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**For residents of District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

**Employee Signature** (This certifies that I have read and understand the above Declaration and Fraud Warnings).

X _____ X _____

***SIGNATURE OF THE EMPLOYEE*** ***DATE***