



COVID - 19 Joint Application
Accident and Sick (A&S) - TES Benefits

**IBEW Local No. 1 Health and Welfare Fund
Electricians Income Security Fund**

5735 Elizabeth Avenue
Saint Louis, MO 63110

Phone 314/752-2330
Fax 314/752-2339

1. Participant Information (Please print or type)

| | | | | |
|---------------------|---|-----------|--------------------------|----------|
| First Name | MI | Last Name | Social Security Number | |
| | | | | |
| Street Address | | City | State | Zip Code |
| | | | | |
| Mobile Phone Number | Email Address | | Date of Birth | |
| | | | | |
| Last Employer | Last Day of Work Prior to Displacement/Exposure | | Last Day of Displacement | |
| | | | | |

Complete Either Section 2 or 3 Below, Whichever Applies (Both Will Likely NOT Apply)

2. Work Related Displacement or Reduction in Workforce

Displacement (Furlough) - Employer verification will be required, the following applies to my displacement:
 I was denied work due to project closure, employment reduction or other customer reaction to the pandemic.
 I am honoring a "Shelter at Home" order and my employer certifies no work is available for me.

Reduction in Workforce - My employer reduced workforce, the following applies to my reduction in work

COVID-19 Related Layoff - I received a layoff due to COVID-19 related circumstances.

Unrelated Layoff - I received a layoff, due to circumstances unrelated to COVID-19.

State Unemployment - In addition to applying for TES Benefits, I intend to apply for State Unemployment

***If you completed this section, please complete Section 4 (TES Withholding Certificate) below.**

3. Exposed, At Risk or Caregiver (you may be requested to provide certain documentation to verify eligibility)

Exposed Participant - I was exposed and being treated for COVID-19 or I am in quarantine, due to personal possible exposure or the possible exposure of a family member.

At Risk Participant - I have an underlying medical condition or have a family member with whom I reside, with an underlying medical condition that puts me or them at heightened risk if exposed to COVID-19 (ex. weak immune system)

Caregiver - I am providing care to a family member of the same household diagnosed with COVID-19 or the primary caregiver for a child or other person in my household who is unable to attend school or another facility due to COVID-19. There is no other individual within the household who is able to serve this role.

***If you completed this section, please complete Sections 4 and 5 (both Withholding Certificates) below.**

4. TES Withholding Certificate (complete W-4 is available upon request)

1. Marital Status - Single Married Married, But Withholding at a Higher Single Rate
Please note - if married, but legally separated, or spouse is non-resident, check the Single box.

2. Total Number of Allowances.....

3. Additional Amount, if any, you want deducted from each TES payment..... \$

4. I claim exemption from withholding (check the following that apply):

(a) Last year I did not owe any Federal Income Tax and had a right to a full refund, AND

(b) This year I do not expect to owe any Federal Income Tax and expect to have a right to a full refund. If both (a) and (b) apply, enter the year effective and EXEMPT here

(c) Are you a full time student? Yes No

5. Accident and Sick Withholding Certificate (complete W-4 is available upon request)

I request Federal Income Tax withholding from each of my Accident and Sick payments (optional): \$

Please note - FICA is withheld, Federal is optional and State tax is not withheld from A&S Benefits.

6. Signature and Certification of Participant

I hereby certify the foregoing statements, including any accompanying statements are true, correct and complete to the best of my knowledge and also hereby certify the withholding exemption and allowances claimed do not exceed the number in which I am entitled.

| | |
|-----------------------|------|
| Participant Signature | Date |
| | |