Roofers' Local #195

Health, Accident & Pension Funds

7706 Maltlage Drive   Liverpool, NY 13090

Phone: (315) 699-1388   Fax: (315) 699-1390

June 12, 2018

Application Instructions for
Supplemental Disability Payments and Disability Allocation of
Health Insurance Premiums with Physicians Verification Statement

You have made a request to our office for forms in reference to collecting the Disability Allocation Benefit. Enclosed are the proper physician's statements that must be completed by your physician **each month during your period of disability. Proof of continuing disability must be furnished or your credits will stop until proof is rendered.**

You must supply a copy of your Workers Compensation claim filing or your filing for New York State Disability. This may be obtained through your employer.

If you have any questions in regards to this benefit, you man refer to Page 5 of the Summary Description Booklet. Furthermore, this benefit is not available to those participants receiving benefits through the "Direct Payment Plan" (Page 16), or COBRA Continuation Coverage (Page 17).

You must notify this office immediately upon the physician's release of you for your return to full employment.

Please note: No more then three monthly Disability Allocations (total or partial payments) will be made for any one participant during his/her lifetime.

Please return all completed forms to:

Roofers Local #195 Fund Office
6200 State Route 31
Cicero, NY 13039

If you have any questions, please call our office.

Sincerely,
Patricia Redhead
Plan Manager

bld/enc

Roofers' Local #195

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APPLICATION FOR SUPPLEMENTAL DISABILITY PAYMENTS AND DISABILITY APPLICATION FOR HEALTH INSURANCE PREMIUMS

Name:____

Soc. Sec. No.____Date of Birth_____/____/_______

Address:____

____Phone No.____________________

What is the disability, illness or type of injury?

____

____

Is the disability due to occupational sickness or injury?___________________________________

Employer:____Phone No.____________________

Date Injury Occurred:__________/_______/_______

If this in not an occupational injury, where did the injury occur:____________________________

____

Date you became disabled:____

Have you filed or currently collecting one of the following:

New York State Disability:_____________________New York State Compensation:_________________

***You must enclose proof that you are in receipt of benefits under the NYS Disability Law or State Workers' Compensation Law**.

Treating Physician Name:____

Address:____

Phone: ______________________________ Fax: ______________________________________

***You must have the above physician complete and return the enclosed physicians verification statement, to complete your application.**

Date of eligibility is determined by the date you became disabled. ***Continued proof of disability is required every two weeks.***

____

Participant's Signature Date

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June 12, 2018

DISABILITY ALLOCATION FOR HEALTH INSURANCE PREMIUMS

PHYSICIAN'S VERIFICATION STATEMENT

Claimant's Name:________________________________S.S. #: ______-_____-______

Diagnosis/Analysis:____

Has Claimant been hospitalized?_______________Date(s):_______________________

Is this disability due to occupational injury or illness:____________________________

Please list the following dates:

Date of your first treatment for this disability?__________________________________

Date of your most recent treatment:____

Date claimant was unable to work due to this disability:__________________________

Date claimant will return to work*:____

***Claimant must submit doctors continued proof of disability <u>each month</u>**.

Physicians Name:____
(Please Print)

Address:____

Phone #:____________________________Fax # :______________________________

I certify that I am a licensed physician in the State of ____________________________

License No.____________________

____
Signature of Physician Date

ONCE COMPLETED FAX BACK TO (315) 699-1390 - ATTENTION: BRENDA

Roofers' Local #195
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DISABILITY APPLICATION CHECK LIST
(THIS PAGE IS TO BE COMPLETED BY THE FUND OFFICE ONLY)

MEMBER'S NAME____

THE FOLLOWING ITEMS SHOULD BE NOTED IN THE FILE AND SUPPORTED DOCUMENTS ATTACHED IF NEEDED.

1. APPLICATION:
   a. Signed __________________________
   b. Date Received __________________________

2. Physician Verification Statement
   a. Signed __________________________
   b. Date Received __________________________

3. PROOF OF DATE OF DISABILITY
   a. NYS Disability __________________________
   b. Workers Compensation __________________________

4. PRIOR PERIODS OF DISABILITY CREDIT
   a. No __________________________
   b. Yes __________________________
      Period of Disability Credit _________________________________
      Did the period reach the maximum three-month credit? ________________

OFFICE APPROVAL/DENIED:

Approved: ____

Period Covered: ____

Additional proof is required for following Month(s):_________________________________

Premiums Amount Credited:
   Month 1: ___________
   Month 2: ___________
   Month 3: ___________

Disability Payments:
#1 __________ #4 __________ #7 __________ #10 ________
#2 __________ #5 __________ #8 __________
#3 __________ #6 __________ #9 __________

Denied due to: ____
Denial Sent: ____

Plan Manager ____**Date:** _____________