Roofers' Local #195
Health, Accident & Pension Funds
6200 State Route 31 Cicero, NY 13039
Phone: (315) 699-1388 Fax: (315) 699-1390

April 3, 2008

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

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April 3, 2008

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

Roofers' Local #195

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April 3, 2008

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

MEMBER'S NAME_____________________________________

ROOFERS LOCAL 195 Health Fund
DISABILITY APPLICATION CHECK LIST

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):______________________________

Amount Credited:
Month 1: __________
Month 2: __________
Month 3: __________

Denied due to: ____

Denial Sent: ____

Plan Manager ____**Date:** _____________