LOSS OF TIME CLAIM FORM

Complete and Return to:
Roofers' Local Union No. 33
53 Evans Drive P.O. Box 9106
Stoughton, Massachusetts 02072

SECTION TO BE COMPLETED BY ELIGIBLE (Please Answers All Questions Fully

I hereby apply for benefits as a participant in the Health & Welfare Fund on account of total disability **WHICH IS IN NO WAY CONNECTED WITH OR DUE** to my employment.

1. Name _____ Date of Birth _____
   First Middle Last
2. Home Address _____ Telephone _____
3. Social Security Number _____
4. Date total disability commenced? _____
5. I Last worked for _____ on _____ A.M. / P.M.
   Employer *Date*
6. I returned to work on _____ A.M. / P.M.
7. If not returned to work, when do you expect to return? _____
   Date
8. Is this claim based on an accident? Yes ☐ No ☐ If yes, did accident occur on-the-job? Yes ☐ No ☐

   Give date of accident _____

   Where did accident occur? _____

   How did it happen? _____

   _____
9. Are you now receiving Unemployment Benefits? Yes ☐ No ☐ Workers' Compensation Benefits? Yes ☐ No ☐
10. Are you employed at any other job either on full-time or part-time basis? Yes ☐ No ☐ If yes, please give full details regarding this employment, including name and address of employer.

    _____

    _____

I AUTHORIZE any physician, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company, or employer having information available as to diagnosis or treatment with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give to Roofers' Local 33 Health & Welfare Fund or its legal representative any and all such information.

I UNDERSTAND the information obtained by use of the authorization will be used by Roofers' Local 33 Health & Welfare Fund to determine insurance and eligibility for benefits under my existing policy. Any information obtained will not be released by Roofers' Local 33 Health & Welfare Fund to any person or organization EXCEPT to reinsuring companies or other persons or organization performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization shall be valid for the duration of the policy.

_____
Signature

_____
Telephone

_____
Date

☐ Check if you have filed a claim for WORKERS COMPENSATION, UNEMPLOYMENT, or if a THIRD PARTY or attorney is involved in this case. (Circle type of claim)

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name and Address	Age:
Diagnosis and Concurrent Conditions (If Fracture or Dislocation, Describe Nature and Location) Is condition due to injury or sickness arising out of patient's Employment? If "YES" explain	☐ Yes ☐ No
When did symptoms first appear or accident happen? When did patient first consult you for this condition? Has patient ever had same Or similar condition? If "YES" state when and describe	Date_____ Date:_____ ☐ Yes ☐ No
Nature of Surgical or Obstetrical Procedure, if any. (Describe fully) If performed in hospital, give name of hospital	Date performed:_____ ☐ Inpatient ☐ Outpatient
Give dates of other medical (non-surgical) treatment, if any.	Office_____ Home_____ Hospital_____
Is patient still under care for this condition? If "NO" give date your services terminated	☐ Yes ☐ No Date:_____
How long was or will patient be continuously totally disabled (*Unable to Work*) ? Was house confinement necessary? If "YES" give dates	From_____ Thru_____ ☐ Yes ☐ No From_____ Thru_____

Does Patient have other Health Coverage?

Physician's Tax ID:_____

Date | Physician's Name (print) | Signature | Degree | Telephone

Street Address | City or Town | State or Province | Zip Code

THIS SECTION TO BE COMPLETED BY FUND OFFICE

Member Effective Date: _____

Member Termination Date: _____

I certify that the patient named in this claim was eligible for medical benefits during the period specified above.

Policyholder's Representative: _____

Date: _____