HEALTH FUND – ALERT
YOU MUST BE CURRENTLY ELIGIBLE FOR HEALTH FUND BENEFITS TO RECEIVE LOSS OF TIME PAYMENTS AND CREDITS OR CREDITS WHEN OFF ON WORKERS COMPENSATION.

1) YOU ARE OUT BECAUSE OF A NON-WORK RELATED INJURY
   LOSS OF TIME
   a. Contact the Milwaukee Roofers Health Fund – to obtain a Benefit Claim Form
   b. Form that must be completed by you and your Attending Physician(s)
   c. The Completed Form must be sent to the Milwaukee Roofers Health Fund (this must be done within 30 days of any incident)
   d. You will receive payment of $45.00 per day-
      Based on information provided on the completed Benefit Claim Form
   e. You will receive Credit of up to 100/hours for every calendar month in which you may be off work for at least 20 days-
      Based on information provided on the completed Benefit Claim Form.

2) YOU ARE OFF BECAUSE OF A WORK RELATED INJURY
   WORKMENS COMPENSATION CLAIM.
   a. Contact the Milwaukee Roofers Health Fund – to obtain a Benefit Claim Form
   b. Form must be completed by you and your attending physician(s)
   c. The Completed B/C Form must be sent to the Milwaukee Roofers Health Fund (this must be done within 30 days of any incident)
   d. You WILL NOT receive payments from the Health Fund –
   e. You will receive Credit of up to 100/hours for every calendar month in which you may be off work for at least 20 days

3) Receiving Credits of up to 100/hours per calendar month in which you are off at least 20 days.
   a. DOES NOT INSURE YOUR CONTINUED ELIGIBILITY FOR BENEFITS OR KEEP YOUR INSURANCE THRU THE HEALTH FUND.
   b. REMEMBER, to maintain eligibility in the Health Fund you must maintain at at least 600/hours in the last current 6/month period OR 1200/hours in the last current 12/month period.
   c. Even when receiving the up to 100/Hour credits your hours may fall below the 600 hours in 6/months and the 1200 hours in the 12/months.
   d. If you receive A SELF-PAYMENT NOTICE - DO NOT IGNORE IT OR THROW IT AWAY. YOU WILL LOSE YOUR ELIGIBILITY IN THE HEALTH FUND – CALL THE HEALTH FUND OFFICE IF YOU DO NOT UNDERSTAND THE BILL OR IF YOU HAVE QUESTIONS.

In recent months, we have had participants who have been on Workers Compensation or on Loss of Time that have received Self-Payment Notices because their hours were not enough to maintain their eligibility. They ignored the notice or threw it away. Yes they lost their eligibility in the Health Fund and their insurance was terminated. These participants are then shocked when they seek medical treatment and find they do not have insurance coverage.

IT WOULD BE WISE TO UNDERSTAND YOUR BENEFITS AND THE ELIGIBILITY RULES – READ YOUR SPD (Summary Plan Description – 3/ring white binder) AND/OR CALL THE HEALTH FUND OFFICE BEFORE IT IS TO LATE (AFTER YOU HAVE LOST ELIGIBILITY).

COVERAGE WHILE DISABLED
BENEFIT CLAIM FORM

Check your Summary Plan Description for Health Fund Benefits.

Both you and your attending physician must complete the enclosed Benefit Claim Form.

Claims are processed and checks cut every (2) two weeks on Thursdays. (If you are off on Loss of Time not Workers Compensation) you should receive your checks within a week of the date processed.

Please be advised that the disability period can only be granted up to the date the Physician signs the form. When a Benefit Claim Form is received and processed another blank Benefit Claim Form will be sent along with your benefit letter. This will continue each month until you are released for work or until the benefits expire as per the Summary Plan Description.

EXAMPLE:
The Physician states – See back of form. Date this form received, April 16, 2013.
(8) Patient was continuously totally disabled (Unable to work)
From: April 7, 2013 thru May 1, 2013.

Physician signs the form – April 12, 2013.

The period of time that may be considered is between the time the Physician states that the participant was unable to work.

From: April 7, 2013 through the date the Physician signs the form, in this case April 12, 2013.
Loss of time payments in this case would be (5) days.

No hours or dues would be considered until off at least 20 days in a calendar month.

The Physician stated that this participant would be off until May 1, 2013. That is a future date and cannot be considered for a current benefit.

If you are off on a Workers Compensation Claim- Benefit Claim Forms should be completed by you and your Physician only after 20 days has elapsed in a **calendar** month. Health Fund hour credits and dues considerations are granted only after 20 days has elapsed in a calendar month.

If you have any questions, please contact Cheryl at the Health Fund office. (262) 785-9720.

Milwaukee Roofers Health Fund
Board of Trustees

RETURN COMPLETED FORM(S) TO:

MILWAUKEE ROOFERS HEALTH FUND
ROOFERS LOCAL #65
16601 W. DAKOTA STREET
NEW BERLIN, WI 53151-3540
P: 262-785-9741 F 262-785-9721

BENEFIT CLAIM FORM

INSTRUCTIONS: This form to be completed by the member and the attending physician
MEMBER: Complete PART "A" FULLY - Sign and Date
PHYSICIAN: Complete PART "B" FULLY - Provide physician information - sign and date

PART A MEMBER COMPLETES AND SIGNS THIS SECTION

FOR ALL BENEFIT REQUESTS

Name of Member: ______________________

Home Address: ______________________

City: ______________ State: ______________ Zip: ______________

Phone No.: (____) ______________ Social Security No.: ______________

Show Date Last Worked: ______________ Resumed Work: ______________

Employer's Name: ______________________

Nature of Sickness of Injury: ______________________

Date of Sickness or Injury: ______________ Date First Treated: ______________

If injured, how and where did accident happen?: ______________________

Did injury occur in the course of employment? ____ Yes ____ No

Have you, or do you intend to file this disability under Workmen's Compensation? ____ Yes ____ No

Is this disability eligible for Medicare benefits of Social Security Disability? ____ Yes ____ No

Are you currently collecting Unemployment Benefits? ____ Yes ____ No

OTHER REMARKS: ______________________

MEMBER'S SIGNATURE

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by Milwaukee Roofers Health Fund or Roofers Local #65 of any facts concerning the injury, illness or treatment of myself or my dependents. **Only the original signed Benefit Claim Form is accepted, faxed copies are not**.

Dated ______________ 20____ (Signed) ______________

ATTENDING PHYSICIAN'S STATEMENT

PART B

1. DIAGNOSIS AND CONCURRENT CONDITIONS
   (If diagnosis code other than ICDA* used, give name):

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?
   ___ YES ___ NO

PREGNANCY ___ YES ___ NO
If Yes, approximate date pregnancy commenced. DATE ________

3. REPORT OF SERVICES

DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED

tO - Doctor's Office | IH - Inpatient Hospital | NH - Nursing Home
H - Patient's Home | OH - Outpatient Hospital | OL - Other Locations

4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED?

5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION?

6. PATIENT EVER HAD SAME OR SIMILAR CONDITION?
   _ YES ___ NO If "Yes" when and describe: ________

7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?
   ___ YES ___ NO

8. PATIENT WAS CONTINUOUSLY TOTAL DISABLED
   (Unable to work).
   From ________ Thru ________

9. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK?

Physician's Name (PRINT) | Degree | Telephone

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

PHYSICIAN MUST DATE AND SIGN THIS FORM UPON COMPLETING

DATE: ________ SIGNATURE: ________
Physicians Signature