Roofers & Waterproofers Local Union 44
Welfare Fund

1651 East 24th Street Cleveland, OH 44114
(216)771-8220 Fax (216) 771-1481

GROUP HEALTH CLAIM REPORT
WEEKLY INDEMNITY FOR LOSS OF WORK DUE TO SICKNESS OR INJURY

PART I **EMPLOYEE'S STATEMENT**

Instructions: **1. Complete this Part I**
2. Have your Doctor complete Part III
3. Return the form to the Plan Administrator

Complete for all claims Phone_____

Employee's Name (please print)_____

Address_____

Date of Birth_____ Social Security Number_____

Are you entitled to benefits under workman's compensation for this claim? (Circle one) YES NO

Complete only if Disability is due to an accident

Date of Accident_____ Time accident happened_____

where and how did it occur?_____

_____

Authorization to release information: I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to myself or my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services.

Signed: _____ Date _____
(Insured Employee)

PART II **ADMINSTRATIVE USE ONLY DO NOT WRITE BELOW THIS LINE**

Date received:_____ Benefit Classification _____

Eligibility Date _____ Hours in past 12 months _____

Certificate NO. _____ Gross Benefit _____

Total Weeks Paid _____ Workman's Comp. Ded. _____

Total Amount Claim_____ Net Weekly Benefit _____

Roofers & Waterproofers Local Union 44
Welfare Fund

1651 East 24th Street Cleveland, OH 44114
(216)771-8220 Fax (216) 771-1481

AUTHORIZATION TO RELEASE INFORMATION IS GIVEN IN EMPLOYEE STATEMENT ON REVERSE SIDE

PART III ATTENDING PHYSICIAN'S STATEMENT

1. Patient's name _____ Age _____
2. Nature of sickness or injury (describe complications, if any) _____

   _____

   _____
3. Did this sickness or injury arise out of patient's employment? YES No

   If "yes", explain _____

   _____

   Is disability due to pregnancy? YES NO
4. Nature of surgical procedure, if any (describe fully) _____

   _____

   _____
5. Date performed? _____ Inpatient_____ Out Patient _____
6. Give dates of treatment:

   Office _____
   Home _____
   Hospital_____
7. What other services, if any, did you provide the patient? (itemize, giving dates)

   _____

   _____
8. If patient was referred to you, give name of referring doctor _____
9. The patient has been continuously disabled (unable to work) from _____ through _____
   If still disabled, through which date, at minimum, will the participant be unable to work? (Knowing that this date may later be extended) _____
10. REMARKS: _____

    _____

Signed _____ **M.D.** Date _____
(Attending Physician)

Address _____