Roofers' Unions Welfare Trust Fund
Administered by Wilson-McShane Corporation

Fund Office
2021 Swift Drive, Suite B
Oak Brook, IL 60523

Phone: (847) 827-1029
Fax: (630) 928-1677

NON-OCCUPATIONAL WEEKLY DISABILITY BENEFIT CLAIM FORM

All questions must be answered before benefits are considered

Employee Information (To be completed by the employee)

Name _____ ID# _____

Address _____

City _____ State _____ ZIP _____

Date of Birth _____

Date injury occurred or sickness began _____

Date first treated _____

Fire Date you were unable to work _____

Date you returned to work _____

If injury, where did it occur _____

_____

How did it occur _____

_____

Was injury or sickness caused by your employment Yes ☐ No ☐

I certify that the above information is true and correct. I hereby authorize all doctors, hospitals, or other institutions rendering care and treatment to furnish Roofers' Unions Welfare Trust Fund with full information regarding treatment rendered (including copies of their records). I authorize Roofers' Unions Welfare Trust Fund to obtain from or release to any union, trust fund, employer or insurance carrier, all information regarding benefits to which I may be entitled and for these organizations to release to Roofers' Unions Welfare Trust Fund any such information.

Employee's Signature _____ Date _____

Please have your physician complete the reverse side of this form.

Physician's Statement of Disability

To be completed by the Physician treating the disabling disorder.

Patient's Name _____ Date of Birth _____

Diagnosis _____ ICD Code _____

_____

Date patient first consulted you for this condition _____

Plan of treatment _____

_____

List of reasons why patient is totally and continuously disabled and unable to return to work

_____

_____

_____

Is patient still under your care for this condition Yes ☐ No ☐

First date of disability _____

Return to work – Estimated _____

Actual _____

Print Full Name of Physician _____

Physician's Address _____

_____

City State Zip

Physician's Signature _____ Phone Number_____

Tax ID# _____ Date _____