WEEKLY DISABILITY BENEFITS

Only eligible employees other than those making payments to the Plan on their own behalf may receive weekly income benefits. If you become totally disabled because of a non-occupational disability and remain under the care of a doctor (M.D. or D.O.), you will receive the weekly benefits set out in the Schedule of Benefits. No benefit is payable for any period for which you are entitled to receive workers' compensation benefits. The benefit payable under this provision will be paid to you after the waiting period specified in the Schedule. For any separate period of disability, payments will continue until the total disability ends or you reach the end of the benefit period, whichever happens first. Claim Forms can be obtained by the Fund Office or the website www.bmgiweb.com/441. Claims need to be submitted to the Plan Administrator by Mail, E-mail or Fax.

You are totally disabled if you cannot perform the duties of your own occupation or any other work for remuneration or profit because of injury, sickness, or pregnancy.

No weekly income benefit will be paid under this Plan for any period in which you are disabled because of an intentionally self-inflicted injury, war or any act of war, the commission of a felony, participation in a riot, or participation in aeronautic activities except as a passenger. The Plan Administrator reserves the right to request a physical examination by a physician of the Plan Administrator's choosing, as a prerequisite to provide further weekly income benefits.

Benefits begin on the eighth day of continuous disability due to accident or sickness.

The maximum for each period of disability is 182 days. Two or more periods of disability due to the same cause are considered one period of disability, unless they are separated by your return to full-time work for a continuous period of at least 30 days.

If weekly income is paid for the maximum number of days, a new period of disability due to the same or a related injury or sickness will not be allowed, unless separated by your return to the full-time duties of your regular occupation for a continuous period of at least 30 days.

SCHEDULE OF DISABILITY BENEFITS

Weekly Disability Benefit	
Occupational Disabilities	None
Non-Occupational Disabilities	$300* or 66-2/3% of weekly compensation, whichever is less
Waiting Period	
Accident	7 days
Sickness	7 days

* Weekly Disability payments are subject to FICA Tax.

PLUMBING AND PIPEFITTING INDUSTRY
HEALTH AND WELFARE FUND OF KANSAS
529 South Anna Street, Ste B
Wichita, KS 67209

PHONE (316) 264-2339
FAX (630) 230-3913

E-MAIL: mlindholm@bmgiweb.com

INITIAL REPORT FOR GROUP LOSS OF TIME BENEFITS

THIS SECTION TO BE COMPLETED BY INSURED MEMBER

MEMBER'S FULL NAME		DATE OF BIRTH		SOCIAL SECURITY #
ADDRESS	CITY	STATE	ZIP CODE	AREA CODE - PHONE #
DATE YOU WERE FIRST UNABLE TO WORK		DATE YOU RETURNED TO WORK (IF APPLICABLE)		
WAS DISABILITY WORK RELATED? YES ☐ NO ☐	HAS THERE BEEN, OR WILL THERE BE, A CLAIM FILED FOR THIS DISABILITY WITH A WORKMAN'S COMPENSATION CARRIER? YES ☐ NO ☐			
IF YOU WERE INJURED ⇨	DATE ACCIDENT OCCURRED?	TIME ACCIDENT OCCURRED?		
WERE YOU AT WORK WHEN ACCIDENT OCCURRED? YES ☐ NO ☐	DESCRIBE THE ACCIDENT			
DESCRIBE THE DISABILITY				
NAME & ADDRESS OF CURRENT EMPLOYER LOCAL UNION 441				

I HEREBY CERTIFY THE STATEMENTS HEREON & ATTACHED ARE COMPLETE & ACCURATE.
I AUTHORIZE ANY PERSON OR INSTITUTION RENDERING CARE OR ANY PERSON OR ORGANIZATION IN POSSESSION OF INSURANCE OR OTHER BENEFIT INFORMATION CONCERNING ME, TO FURNISH OR DISCLOSE ALL KNOWN FACTS CONCERNING THIS DISABILITY. A COPY OR PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
IF MY CLAIM IS ACCEPTED AS VALID AND IF THE PLAN SHOULD DECIDE IT IS NECESSARY, I AGREE TO A PHYSICAL EXAMINATION BY A PHYSICIAN OF THE ADMINISTRATOR'S CHOOSING, AS A PREREQUISITE TO FURTHER LOSS OF TIME BENEFITS.

DATE	EMPLOYEE'S SIGNATURE

` **OPPOSITE SIDE TO BE COMPLETED BY ATTENDING PHYSICIAN**

PLUMBING AND PIPEFITTING INDUSTRY
HEALTH AND WELFARE FUND OF KANSAS
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ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME	DOB

DIAGNOSIS AND CURRENT CONDITIONS

DATE & DESCRIPTION OF SURGICAL PROCEDURES

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?

☐ YES ☐ NO

DATES OF SERVICES AND OFFICE VISITS

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT OCCURRED:	DATE PATIENT FIRST CONSULTED YOU FOR THIS:

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?	IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?
☐ YES ☐ NO	☐ YES ☐ NO

PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK):

FROM: TO:

IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK WITHOUT ANY RESTRICTIONS	WERE YOU THE FIRST PHYSICIAN TO TREAT THE PATIENT FOR THIS CONDITION?
	☐ YES ☐ NO

PHYSICIAN'S NAME (PLEASE PRINT)		PHYSICIAN'S SS# OR EMPLOYER ID#		
ADDRESS	CITY	STATE	ZIP CODE	AREA CODE-PHONE #

PHYSICIAN'S SIGNATURE	DEGREE	DATE