STATEMENT OF APPLICANT

IMPORTANT - PLEASE ANSWER ALL QUESTIONS AND SUPPLY ALL DATES

1. Give exact date when illness or disability began _____
2. Did the illness or disability prevent you from following your usual or other occupation? _____
3. When did the present illness or disability require you to stop work? _____
4. Give the date when you were first attended by a physician for this illness or disability _____
5. Give the names and addresses of all physicians in attendance during this disability _____

_____

6. Are you still sick or disabled? _____ 7. When did you return to work? _____
8. If unemployed, when did you recover? _____
9. If present illness or disability is due to accident, did it happen in the course of your occupation? _____
10. If due to an accident, state how the accident occurred. _____

_____

11. Have you previously received benefits for the illness from which you are now suffering? _____
12. How many attacks of this or similar ailments have you had and when? _____
13. What is your occupation? _____
14. Where are you employed? _____

I hereby warrant the truth of the answers to the above questions.

Signature of Member _____ Address _____

City, State, Zip _____ Assembly Name & No. _____

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PHYSICIAN'S STATEMENT

1. When did you first see the above applicant for their present illness or disability? _____
2. Name of disease or nature of disability (Please give full particulars, organ or part involved or pathology present)

_____

3. Was the illness or disability sufficient to prevent them from their usual occupation or activity? _____
4. Are they now disabled? _____ Are you attending them now? _____
5. When did you last see them for this illness or disability? _____
6. Dates when applicant was seen at office, hospital or home _____
7. When will the applicant be able to return to their usual occupation or activity _____
8. Is it possible to prevent a recurrence of such illness or disability? _____

I hereby certify that the answers to these answers are true and I am a licensed physician.

_____ M.D./D.O.

Date _____ _____ Address

_____ City, State, Zip

ARTISANS ORDER

OF

MUTUAL PROTECTION

8100 Roosevelt Boulevard
Philadelphia, PA 19152

215-708-1000
800-551-1873

APPLICATION

FOR

SICK BENEFITS

Name _____

Assembly Name _____

Assembly No. _____

IMPORTANT INFORMATION

Every member of the Order who, through sickness or disability, he is unable to follow their usual or any other vocation or occupation, shall be entitled to receive from the Contingent Fund of the Subordinate Assembly, of which they are a member, the sum of $15 per week, not exceeding 10 weeks in any period of 52 consecutive weeks upon furnishing satisfactory evidence of such sickness or disability and the certificate of a licensed physician, who attended the member during his/her illness, certifying the nature of such sickness or disability, covering the period for which the benefits are claimed. No payment shall be made for the first weeks sickness or disability, nor for a disease contracted prior to initiation, nor unless proof of illness or disability is filed within 60 days of the period for which the benefits are claimed.

In cases of chronic illness (where the member is continuously sick or disabled from the same cause) the number of weeks paid after two periods of illness or disability shall be limited to five weeks in any period of 52 consecutive weeks. In case of sickness or disability it shall be the duty of the member claiming benefits to report to the main office.

Any member who shall upon trial be convinced of having obtained benefits from the Subordinate Assembly illegally, or on account of assumed or feigned sickness or disability shall be reprimanded and be deprived of the right of further attendance at the meetings of their own or any other Assembly of the Order until restitution is made.

The physician must hold a license to practice in his/her state.

Benefits are paid for the 10 weeks in any period of 52 consecutive weeks (not calendar year). Each member automatically establishes their own sick benefit year. Look backward one year from the date to which it is proposed to pay the benefits in this report and if any benefits have been paid during that period the member will be entitled to the difference between the number of weeks they have drawn and 10. Benefits begin one week from the day the member is taken sick, provided they are attended by a licensed physician and had been unable to work during that week and report to the main office within 60 days. A member is not sick or disabled within the meaning of our law unless they are attended by a licensed physician. The certificate of the physician must cover the period for which the benefits are drawn. To be eligible for benefits, the member must be wholly unable to follow any occupation, vocation or activity. Benefits are not paid if illness or disability is caused by intemperance or immoral conduct. Where a member is unable to report by reason of being unconscious or delirious, or otherwise Total Disability Benefits will be paid upon proof of sickness or disability. In such cases the application should be supplemented with a written statement from the physician of the facts in the case.