

**LOCAL 802 MUSICIANS HEALTH FUND
APPLICATION FOR SICK PAY BENEFITS**

Applicant must answer all questions and return completed form to: LOCAL 802 MUSICIANS HEALTH FUND, 322 West 48th Street, New York, NY 10036, Phone: (212) 245-4802, ext. 171, 172, 173 and 178, Fax: (212) 245-2304

Important Note: If your completed application is not received in the Fund Office within sixty (60) days of the absence for which you are seeking benefits, your claim will be denied as untimely, subject to your right to appeal to the Fund's Board of Trustees.

Today's date: _____ Card #: _____ (Required)

Name: _____

Address: _____

Number of performances missed because of illness: _____

Dates of performances missed: _____

Total wages lost for those dates (incl. vacation pay & inst. maintenance):

\$ _____

_____ Doubles _____ 1st Trumpet _____ On Stage _____ Costume _____ Choreography _____ Body Paint

_____ Conductor _____ Associate Conductor _____ Synth _____ Contractor _____ 2nd Sunday

_____ Other (please explain) _____

Names of all Broadway shows played since Labor Day*	Theatre
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

*Please note that you earn one day of sick pay for each 52 performances worked under the Broadway/Disney Agreement since the last Labor Day. You must apply for sick pay within 60 days of your absence due to illness, but you will not receive a day of sick pay until you have worked those 52 performances and those performances have been reported to the Fund (absences for paid vacation count as performances).

Prolonged Illness: If you are seeking benefits for an illness that has continued for more than seven (7) consecutive days, please provide a letter from your treating physician that describes the expected duration of your illness.

PARTICIPANT CERTIFICATION: Under penalties of perjury, I certify that the information contained in this form is true and correct to the best of my knowledge and the documents I have submitted are true copies and contain only accurate information to the best of my knowledge. I further certify that I could not play the indicated performance(s) because of illness.

Applicant Signature

CERTIFICATION OF CONTRACTOR: I, _____, certify that I am the contractor at the _____ Theatre and that _____ was absent from work on the dates set forth in the above application, and the reported number of Doubles and the Total Wages lost set forth in the above application are accurate.

Check here if this person is a Substitute.

Contractor Signature

Please note if the Applicant is a Contractor, the Acting Contractor must complete and sign the above certification.

APPROVED – SICK PAY FUND_____

For office use:

CK. # _____ Claim # _____
Rate _____ x _____ performance(s)
Total Gross _____ Net _____
Paid Date _____ Rec'd _____

For office use:

CK. # _____ Claim # _____
Rate _____ x _____ performance(s)
Total Gross _____ Net _____
Paid Date _____ Rec'd _____