

HEAT & FROST INSULATORS AND ALLIED WORKERS LOCAL 47 WELFARE FUND

6525 Centurion Drive
Lansing, MI 48917
Tollfree Telephone: 800-323-8079
Fax: 517-321-7508

STATEMENT FOR LOSS OF TIME BENEFITS

**(Note: Participant must complete this side
Reverse side must be completed by your physician)**

Name:		Date of Birth:	
Address:	City:	State:	Zip:
Member Identification #:		Local Union #:	
Is this claim based on an accident/injury?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Nature of sickness or accident/injury:			
Date sickness or accident/injury began:		Date first treated:	
Did sickness or accident/injury occur in the course of employment?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Where did sickness or accident/injury occur?			
How did sickness or accident/injury happen?			
Have you, or do you intend to file this claim under Workers' Compensation?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
On what date did you last work?			
Have you resumed work?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If YES, what date:			
Are you Retired?: Yes <input type="checkbox"/> No <input type="checkbox"/>		Are you receiving Social Security Disability?: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Signature:		Date:	

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ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's Name:		Date of Birth:	
Member Identification #:			
Diagnosis and Concurrent Conditions:			
ICD9 Code:			
Is this claim based on an accident/injury?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Date sickness or accident/injury began:		Date first treated:	
Is condition due to injury or sickness arising out of patient's employment?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If YES, explain:			
This patient has been continuously disabled (first day unable to work) from _____ through (last day unable to work) _____.			
Exact date patient will be able to return to work at trade:			
If exact date is unknown, please estimate:			
Is patient still under your care for this condition?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
If YES, give date of last treatment:			
If YES, give date of next scheduled appointment:			
If NO, give date treatment terminated:			
Physician's Signature:		Date:	
Physician's Name (please print)		Degree:	
Address:			
City: State: Zip:			
Telephone Number:			
Fax Number:			