IBEW LOCAL NO. 150 WELFARE FUND

6525 Centurion Drive
Lansing, MI 48917
Toll Free: 877-478-4542

LOSS OF TIME FORM

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

Name:		Date of Birth:	
Address:	City:	State:	Zip:
Member ID or SSN #:		Local Union #:	
Is this claim based on an accident/injury?		Yes ☐	No ☐
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 ☐	No ☐
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 ☐	No ☐
On what date did you last work (before becoming totally disabled)?			
Have you resumed work?		Yes ☐ No ☐	
If YES, what date:			
Are you Retired?: ☐ Yes ☐ No		Are you receiving Social Security Disability?: ☐ Yes ☐ No	

I hereby authorize any insurance company, provider, or any other organization to release all information to IBEW Local No. 150 Welfare Fund, which may have a bearing on the benefits payable under this Plan. A photocopy of this authorization will be as effective as the original.

Signature: Date:

Telephone Number (Including area code):

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ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's Name: Member ID or SS #:		Date of Birth:
Diagnosis and Concurrent Conditions: ICD9 Code:		
Is this claim based on an accident/injury?	Yes ☐	No ☐
Date sickness or accident/injury began:	Date first treated:	
Is condition due to injury or sickness arising out of patient's employment?	Yes ☐	No ☐
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 ☐	No ☐
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: (Please include area code)		