IBEW LOCAL NO. 150 WELFARE FUND

230 Lexington Green Circle Ste 400
Lexington KY 40503
Toll Free: 888-999-7741

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)			