Return Form To:
West Virginia Laborers Trust Fund
One Union Square
Suite 200
Charleston, WV 25302
Phone: (304) 342-5142
Fax: (304) 342-2610

STATEMENT OF CLAIM FOR GROUP INSURANCE BENEFITS
(FOR EMPLOYEES)

INSTRUCTIONS: This form must be submitted by the insured to the office of the Trust Fund properly and fully completed and signed by himself, his physician, and his employer.

TO BE COMPLETED BY INSURED EMPLOYEE

1. WHAT IS YOUR FULL NAME?_____ DATE OF BIRTH:_____
2. WHAT IS YOUR HOME ADDRESS?_____
   STREET CITY STATE
3. ON WHAT DATE WERE YOU FIRST TOTALLY DISABLED BY THE SICKNESS OR INJURY?_____
4. ON WHAT DATE WERE YOU FIRST TREATED BY A PHYSICIAN?_____ ON WHAT DATE DID YOU LAST WORK?_____
5. IF THIS DISABILITY IS DUE TO ACCIDENT, ANSWER THE FOLLOWING:
   (A) WERE YOU AT WORK WHEN THE ACCIDENT HAPPENED? (ANSWER "YES" OR "NO")_____
   (B) WHEN AND WHERE DID THE ACCIDENT HAPPEN?_____
   (C) DESCRIBE THE ACCIDENT. TELL HOW IT HAPPENED:_____
6. HAVE YOU RETURNED TO WORK?_____ (A) IF SO, ON WHAT DATE?_____
   (B) IF NOT, WHEN DO YOU EXPECT TO RETURN TO WORK?_____

DATE:_____

OVER

TO BE COMPLETED BY EMPLOYER OF INSURED EMPLOYEE

1. FROM WHAT DATE WAS HE CONTINUOUSLY EMPLOYED?_____
2. ON WHAT DATE DID HE LAST WORK PRIOR TO HIS DISABILITY?_____ WKLY. WAGE $_____
3. IS THIS DISABILITY THE RESULT OF INJURY OR OCCUPATIONAL DISEASE ARISING OUT OF OR IN THE COURSE OF EMPLOYMENT?_____
4. IF THE CAUSE OF DISABILITY WAS OCCUPATIONAL, HAS IT BEEN REPORTED TO THE STATE BOARD OR COMMISSION OR TO ANY INSURANCE COMPANY AS A WORK-MEN'S COMPENSATION CLAIM?_____ IF NOT, PLEASE STATE THE REASONS:_____
5. IF THE EMPLOYEE HAS RETURNED TO WORK, PLEASE INDICATE EXACT DATE_____

_____
(NAME OF EMPLOYER)

DATE:_____ BY:_____

TITLE:_____

(OVER)

ATTENDING PHYSICIAN'S STATEMENT

(1) Patient's name_____ Age_____

(2) Nature of sickness or injury (Describe complications, if any)_____

_____

(3) Did this sickness or injury arise out of patient's employment? Yes____ No____

If "Yes," explain_____

_____

(4) Nature of surgical or obstetrical procedure, if any (Describe fully)_____

_____

_____

_____

(5) Date performed_____

Charge for this procedure $ _____

Where performed_____ If in hospital, in-patient____ out-patient____

(6) Give dates of treatments:

	Charge Per Call
Office_____	$_____
Home_____	$_____
Hospital_____	$_____

(7) What other services, if any, did you provide patient? (Itemize, giving dates and fees)_____

_____

_____

_____

(8) The patient has been continuously disabled (unable to work) from_____ through_____

If still disabled, when should patient be able to return to work?_____

(9) Remarks:_____

_____

Date_____ Signed_____ M.D.
(Attending Physician)

Address_____

_____

Phone_____

Insured

Read before signing

To be completed and signed by the insured for payment by Trust Fund to insured and surgeon or physician. This assignment may not be honored if signed by a dependent or person other than the insured.

Date_____

I hereby authorize the W. Va. Laborers' Trust Fund to pay to insured and

Dr. _____ the Medical or Surgical Expense Benefits to which I
(Print Name of Doctor)

am entitled under the terms of the Trust Fund and Certificate to the extent of his interest as established herein.

_____
SIGNATURE OF INSURED