LOSS OF TIME FORM

IMPORTANT – READ CAREFULLY!

1. Fill out Participant's Section, making sure that **Member** signs Claim Form.
2. Have your Employer complete his Section if Time Loss involved.
3. Have your Doctor complete reverse side and include Dates of Disability, if Time Loss involved.
4. Answer all questions, to assure prompt service of your Claim.

Mail Completed Form to:

CONTRACTORS, LABORERS, TEAMSTERS and ENGINEERS HEALTH and WELFARE PLAN
10334 Ellison Circle • Omaha, NE 68134
Telephone: 402-491-3751 • FAX 402-491-0902

STATEMENT OF CLAIM FOR BENEFITS

TO BE COMPLETED BY COVERED MEMBER

1. Member's full name________ Soc. Sec. Number________ Date of birth________ Sex ☐ Male ☐ Female

   Home Address________ Telephone number________
   Number and Street City State Zip Code

   Employed by________ Local or Occupation________ Date employed________

2. Date accident occurred or sickness began________, 20____ ☐ A.M. ☐ P.M.
3. Describe injury or sickness________
4. Date of first treatment for this injury or sickness________, 20____
5. IF INJURED:
   a. Where did the injury occur?________ Date and Hour________
   b. What was claimant doing when the injury occurred?________
   c. Describe the injury: Tell how it happened________
6. Was the injury or sickness caused by any employment? ☐ Yes ☐ No
7. Has there been, or will there be, a claim filed for this disability with the workmen's compensation carrier? ☐ Yes ☐ No
8. First full day unable to work________, 20____ Date returned to work________, 20____
9. Are any hospital, surgical or medical benefits or services provided under any group, or under any federal, state or other governmental program? Also, is above claim covered under any third-party insurance?

   ☐ Yes ☐ No If "yes," give name and address of insurance company or organization providing such benefits or services.________
10. I hereby certify the statements hereon and attached are complete and accurate, and I authorize any person or institution rendering care, or any person or organization in possession of insurance or other benefit information concerning me or my dependents to furnish and disclose all known facts concerning this disability. A copy or photocopy of this authorization shall be as valid as the original.
11. Date________, 20____ Member's signature________Member Sign Here

TO BE COMPLETED BY EMPLOYER IF TIME LOSS INVOLVED (Please type)

1. First full day unable to work________, 20____ Date returned to work________, 20____
2. Is there any possibility this disability was caused by employment? ☐ Yes ☐ No If "yes," explain. ________
3. Name of employer________
4. Date________, 20____Signed________
   Name Title

PLEASE HAVE OPPOSITE SIDE COMPLETED BY ATTENDING PHYSICIAN

LOSS OF TIME FORM

Member name **Age**

Diagnosis and concurrent conditions
(If fracture or dislocation, describe nature and location.)

Is condition due to injury or sickness arising out of patient's employment? If "yes" explain. ☐ Yes ☐ No

Is condition due to pregnancy?
If "yes" what was approximate date of commencement of pregnancy? ☐ Yes ☐ No Date____________________, 20________

When did symptoms first appear or accident happen? Date____________________, 20__________

When did patient first consult you for this condition? Date____________________, 20__________

Has the patient ever had same or similar condition?
If "yes" state when and describe. ☐ Yes ☐ No

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

Date performed________________, 20________

Charge to patient for this procedure including post-operative care.
if performed in hospital, give name of hospital. ☐ Inpatient ☐Outpatient

Give dates of other medical (non-surgical) treatment, if any.

Office____

Home____

Hospital____

Is patient still under your care of this condition?
If "no" give date your services terminated. ☐ Yes ☐ No Date_______________, 20________

How long was or will patient be continuously totally disabled?
(Unable to work?) From_______________, 20___________ Thru___________, 20_________

Date Type or print physician's name and degree

Signature (attending physician) I. D. Number Telephone

Street Address City or Town State or Province Zip Code