FRINGE BENEFIT FUNDS

KANSAS BUILDING TRADES – KANSAS CONSTRUCTION TRADES
4101 SW SOUTHGATE DR
PO BOX 5168
TOPEKA KS 66605-0168
(785)267-0140 OR TOLL FREE (800)432-3595
FAX (785)267-9514

LOSS OF TIME DISABILITY STATEMENT

Instructions:

1. Member is to fill out the Member's Statement
2. Physician to fill out the Physicians Statement on the date the member is seen in the office
3. Send completed for to the Fund Office – Address or Fax number above

Member's Statement

Members Name_____SSN_____
Address_____Date of Birth_____

1. Are you new able to perform the duties of your regular occupation? Yes___ On what date?_____ No ___
2. Are you totally disable at the present time? Yes___ No ___
3. Are you now able to engage in any other type of work? Yes___ No ___
   Type of work:_____
4. Are you presently receiving regular medical care? Yes___ How often? _____
   Doctors Name: _____
5. Have you made application for benefits for this disability from any other source? If yes explain: _____ Yes___ No___
6. Is this injury work related or a motor vehicle injury? Yes___ No___

The above information and answers are true to the best of my knowledge and belief:
SIGNED:_____DATED:_____

ATTENDING PHYSICIANS STATEMENT

1. Diagnosis (ICD-10) and Concurrent conditions:_____
2. Dates of Service(If previous from submitted to this Fund, you need only show dates since last report):
   _____.
3. Patient still under your care for this condition? Yes _____ No_____
4. PATIENT WAS CONTINUOUSLY AND TOTALLY DISABLED FROM: _____TO_____
5. PATIENT WAS PARTIALLY DISABLED FROM:_____TO_____
6. PATIENT WILL BE ABLE TO RETURN TO WORK ON: _____

PHYSICIANS SIGNATURE:_____DATE:_____

ADDRESS:_____PHONE #:_____