Print

INDIANA LABORERS WELFARE FUND

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LOSS OF TIME BENEFIT APPLICATION

*Loss of Time Benefits are paid every two weeks.
*Failure to provide accurate and complete information may delay your Loss of Time Benefit.
*Failure to notify the Claims Department of hours worked could result in an overpayment.
*If you have been released to return to work please have your doctor notify the Fund Office, in writing, of your release date.
*If your doctor disables you beyond the current standard set by the Work Loss Data Institute, medical records will be required to be reviewed for possible continuation of benefits.

(To be completed by Member)

Name _____ SSN or Member ID# _____

Mailing Address (street, city, state, zip) _____ Phone Number _____

Please tell us in detail: how, when and where the injury occurred:

How: _____

When: _____ Where: _____

- Did this specific incident occur while you were working? **Yes** **No**
- Other than this benefit, are any other of insurances responsible for this medical expense? (Homeowner, Worker's Compensation, Auto, Motorcycle or ATV) **Yes** **No**
- If the answer was "Yes" to the question above, do you plan to pursue the responsible party? **Yes** **No**
- Have you or will you hire an attorney? **Yes** **No**

Member's Signature _____ Date _____

***By signing this form, I represent the above information is true. I also authorize the provider listed below to release any medical documentation to process my Loss of Time Benefit Application.

(To be completed by Provider: Please provide as much detailed information as possible, including ICD10 or Surgery Codes in order to avoid delay and allow accurate payment of benefits to this patient).

ICD10 Code(s) with description: _____

Surgical Code(s): _____

Date of First Treatment: _____

Dates of Total Disability: From _____ Through _____

If the patient is still disabled, when should he/she be able to return to work? _____

List Restrictions: _____

Printed name of Doctor _____ Phone number _____

Doctor's signature _____ Date _____