INDIANA LABORERS WELFARE FUND
P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587
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LOSS OF TIME BENEFIT APPLICATION

*Loss of Time Benefits are paid weekly.
*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): ______________________

Dates of Total Disability: From ______________________ Through ______________________

If the patient is still disabled, when should he/she be able to return to work? ______________________
If you return to work without a release from the Physician that date would be considered the release date.

List Restrictions: ______________________

Printed name of Doctor ______________________ Phone number ______________________ Fax number ______________________

Doctor's signature ______________________ Date ______________________

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