INDIANA LABORERS WELFARE FUND

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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 insurances responsible for this medical expense? (Homeowner, Worker's Compensation, Auto, Motorcycle or ATV) **Yes** **No**
- Check the box next to the type of work performed ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy

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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