

Local 292 Health Care Plan

Loss of Time Application

It is the responsibility of the member to see that all sections of this form are completed, questions answered and the form returned to the plan office at **6900 Wedgwood Road N., Suite 425, Maple Grove, MN 55311, Ph. (763) 493-8830 or (800) 368-9045**

Please Type or Print

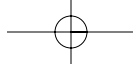
TEAM serves as case manager for Mental Health and Chemical Dependency issues and will make final decision regarding these benefits.

Employee's Statement

1. Name _____ ID Number _____
2. Home Address _____ Phone Number _____
3. Effective Date of Coverage _____ Date of Birth _____
4. I became totally disabled and unable to perform my job in any capacity on _____
5. I last worked preceding disability on _____
6. I returned to work on _____ I expect to return to work on _____
7. Is disability due to accident Yes _____ No _____ If yes, State:
Where _____
When _____ How _____
8. Was the injury incurred while working for profit or wages: Yes _____ No _____ If Yes, explain _____
9. Have you presented, or do you intend to present, a Workers' Compensation Claim: Yes _____ No _____
10. I hereby authorize release of medical information to IBEW Local #292 Health Care Plan to receive Loss of Time Benefits and do certify that the above statement is true. I also authorize release of workability to the IBEW #292 Hiring Hall.
Date: _____ Employee's Signature _____

Employer's Statement

1. Employee _____ Job Title _____
Basic Weekly Wage _____
2. Employer _____
Address _____
3. Has employment terminated? Yes _____ No _____ If Yes, date: _____
4. Date employee last worked preceding disability _____
5. Date disability began _____
6. Has disability ceased: Yes _____ No _____ If Yes, date employee returned to work _____
If not returned, date expected to return to work _____



7. Is Employee entitled to compensation for loss of time due to illness or injury through his employer, i.e., sick leave or salary continuation coverage? Yes _____ No _____ If yes, explain below.

8. Is there any possibility of a claim under Workers' Compensation Act or similar law? Yes _____ No _____

Date signed _____ Employer's Signature _____

Phone No. _____ Position _____

Attending Physician's Statement

LOSS OF TIME (Please Print or Type)

1. Patient's Name _____

2. Name of illness/injury _____ Was patient hospitalized? _____

3. Surgical procedures, if any, _____ Date performed _____

4. Date patient first consulted you for this condition _____

5. Date of most recent treatment _____

6. Frequency of treatment(s) _____

7. If pregnancy, please give delivery date _____

8. Date employee first unable to work due to disability _____

9. Is the employee now, and has the employee been, continuously disabled from performing their job from the above date?
Yes _____ No _____ Remarks, if any _____

10. When will the employee be able to return to work? (Give approximate date) _____

11. In your opinion, is the disability the result of illness or injury arising out of or in the course of employment: Yes _____ No _____
If yes, please explain _____

12. Remarks _____

Date signed _____ Doctor's Signature _____

Doctor's Name _____

Address _____

Send Medical Documentation

Phone Number _____

Doctor's I.D. Number _____

