

# 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 **5100 Gamble Drive, Ste. 430, St. Louis Park, MN 55416, 952-591-7733 or 1-800-368-9045**

**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 \_\_\_\_\_