

# Loss of Time/Disability Medical Update For Continuation of Benefits

**In accordance with the Disability Plan Rules, you are required to be seen by your physician and have this form completed to continue loss of time benefits.**

It is the responsibility of the member to see that questions and information requested are completed and the form returned to the plan office at **5100 Gamble Drive, Ste. 430, St. Louis Park, MN 55416, 612-591-7733 or 1-800-368-9045**

**Please Type or Print**

1. Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

2. Home Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Date of Birth \_\_\_\_\_

3.a) Diagnosis/Injury \_\_\_\_\_

b) Brief History \_\_\_\_\_

4. Surgical Procedure \_\_\_\_\_

5. Date of most recent visit/treatment: \_\_\_\_\_

6. Frequency of treatments: \_\_\_\_\_

7. Does employee continue to be disabled from performing his/her job? Yes \_\_\_\_\_ No \_\_\_\_\_

Remarks if any: \_\_\_\_\_

8. When will employee be able to return to work? (Please estimate)

Doctor's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Doctor's Name \_\_\_\_\_

Address \_\_\_\_\_

**Send Medical Documentation**

Phone Number \_\_\_\_\_

Doctor's I.D. Number \_\_\_\_\_

*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 about statement is true.*

Date \_\_\_\_\_

Employee's Signature \_\_\_\_\_