IBEW LOCAL UNION 697 HEALTH & BENEFIT PLAN

STATEMENT FOR LOSS OF TIME BENEFITS

NOTE: PARTICIPANT TO FILL OUT THIS SIDE

REVERSE SIDE MUST BE COMPLETED BY PHYSICIAN

Participant's Name:		Date of Birth:	
Address:	City:	State:	Zip:
Social Security #:	Phone #:		
Is this claim based on an accident/injury?		☐ **Yes**	☐ **No**
Nature of sickness or accident/injury:			
Date sickness/accident/injury began?	**Date first treated:**		
Did sickness/accident/injury occur in the course of employment?		☐ **Yes**	☐ **No**
Where did sickness/accident/injury occur?			
How did sickness/accident/injury happen?			
Have you, or do you intend to file this claim under Worker's Compensation?		☐ **Yes**	☐ **No**
On what date did you last work?			
Participant's Signature:		Date:	

I hereby certify the statements hereon and attached are complete and accurate, and I authorize any person or institution rendering care, or any person or organization in possession of insurance or other benefit information concerning me to furnish and disclose all known facts concerning this disability. A copy or photocopy of this authorization shall be as valid as the original.

Mail or bring in this form to the Benefits Office: 7200 Mississippi Street, Suite 300, Merrillville, IN 46410
Call our office if you have any questions regarding this form: 219-845-4433 / 219-940-6181

IBEW LOCAL UNION 697 HEALTH & BENEFIT PLAN

ATTENDING PHYSICIAN'S STATEMENT FOR DISABILITY

Patient's Name:		Date of Birth:	
Diagnosis and Concurrent Conditions:			
Is this claim based on an accident/injury		☐ **Yes**	☐ **No**
Date sickness/accident/injury began:	Date first treated:		
Is condition due to injury/sickness arising out of patient's employment?		☐ **Yes**	☐ **No**
If YES, explain:			
This patient has been continuously disabled(first day unable to work) from _____through (last day unable to work)_____.			
Exact date patient will be able to return to work at trade:			
If exact date is unknown, please estimate:			
Is patient still under your care for this condition:		☐ **Yes**	☐ **No**
If YES, give date of last treatment:			
If YES, give date of next scheduled appointment:			
If NO, give date treatment terminated:			
Physician's Signature:		Date:	
Physician's Name (please print):		Degree:	
Address:			
City:		State:	Zip:
Telephone #:			