

Plumbers & Steamfitters Local 33 Health & Welfare Fund Office

2501 Bell Avenue
Des Moines, IA 50321
Telephone: 515-243-3246 (option 1)
Fax: 515-244-6606

STATEMENT FOR LOSS OF TIME BENEFITS

**(Note: Participant must complete this side
Reverse side must be completed by your physician)**

Name:		Date of Birth:	
Address:	City:	State:	Zip:
Member Identification #:			
Is this claim the result of an injury? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Nature of sickness or injury:			
Date sickness or injury began:		Date first treated:	
Did the sickness or injury occur during the course of employment? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Where did sickness or injury occur?			
How did the sickness or injury happen?			
Have you, or do you intend to file this claim under Worker's Compensation or any other type of Insurance (Auto, Homeowners, etc.)? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If this claim was filed under Worker's Compensation, on what date did you last work?			
Have you resumed work? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If YES, what date:			
Are you retired? Yes <input type="checkbox"/> No <input type="checkbox"/>		Are you receiving Social Security Disability? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Signature:			Date:

(Attending Physician must complete the back side of this form)

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ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's Name:	Member Id #:	Date of Birth:
Diagnosis and Concurrent Conditions: ICD9 Code:		
Is this claim based on an injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Date sickness or injury began:	Date first treated:	
Is condition due to sickness or injury arising out of patient's employment? Yes <input type="checkbox"/> No <input type="checkbox"/>		
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 <input type="checkbox"/> No <input type="checkbox"/>		
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 Number:		