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:	Phone Number:	Date of Birth:	
Address:	City:	State:	Zip:
Member Identification #:			
Is this claim the result of an injury? Yes ☐ No ☐			
Have you served in the military? Yes ☐ No ☐ If yes, when did you serve?			
Do you have any medical conditions which occurred during your service? Yes ☐ No ☐ If yes, please detail the date for all illnesses and injuries below & if you have VA benefits for each condition. Date of injury/illness: Type of injury/illness: Do you qualify for VA benefits Yes ☐ No ☐ Date of injury/illness: Type of injury/illness:			
Nature of sickness or injury:			
Date sickness or injury began: Date first treated:			
Last day of work due to sickness or injury:			
Did the sickness or injury occur during the course of employment? Yes ☐ No ☐			
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 ☐ No ☐			
If this claim was filed under Worker's Compensation, on what date did you last work?			
Have you resumed work? Yes ☐ No ☐ If YES, what date:			
Are you retired? Yes ☐ No ☐	Are you receiving Social Security Disability? Yes ☐ No ☐		
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 ☐ No ☐		
Date sickness or injury began:	Date first treated:	
Is condition due to sickness or injury arising out of patient's employment? Yes ☐ No ☐		
Is condition due to sickness or injury arising out of patient's military service? Yes ☐ No ☐		
If YES to either employment or military question, please 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 Number:		