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 complete, questions answered and the form returned to the plan office at **6900 Wedgwood Road N., Suite 425, Maple Grove, MN 55311, Ph. (763) 493-8830 or (800) 368-9045 Fax (763) 416-6196**

Please Type or Print

Employee's Statement

1. Name _____ Social Security 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 _____

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Loss of Time Application
Attending Physician Statement

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Please Type or Print

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 _____

_____

Phone Number _____

Doctor's I.D. Number _____

Send Medical Documentation

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 #292 Hiring Hall.

Date: _____ Employee's Signature _____