

IBEW LOCAL UNION 683 HEALTH & WELFARE PLAN



6525 Centurion Drive
Lansing, MI 48917
(517) 321-7502 • Fax (517) 321-7508
Toll Free (844) 683-0683



LOSS OF TIME FORM

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

Name:		Date of Birth:	
Address:	City:	State:	Zip:
Member ID or SSN #:		Local Union #:	
Is this claim based on an accident/injury?		Yes	No
Nature of sickness or accident/injury:			
Date sickness or accident/injury began:		Date first treated:	
Did sickness or accident/injury occur in the course of employment?		Yes	No
Where did sickness or accident/injury occur?			
How did sickness or accident/injury happen?			
Have you, or do you intend to file this claim under Workers' Compensation?		Yes	No
On what date did you last work (before becoming totally disabled)?			
Have you resumed work?		Yes	No
If YES, what date:			
Are you Retired?:	Yes No	Are you receiving Social Security Disability?:	Yes No
Are you receiving pension benefits?:	Yes No	Are you receiving unemployment?:	Yes No
I hereby authorize any insurance company, provider, or any other organization to release all information to IBEW Local Union 683 Health & Welfare Plan, which may have a bearing on the benefits payable under this Plan. A photocopy of this authorization will be as effective as the original.			
Signature:		Date:	
Telephone Number (Including area code):			

IBEW LOCAL UNION 683 HEALTH & WELFARE PLAN
ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's Name:		Date of Birth:	
Member ID or SS #:			
Diagnosis and Concurrent Conditions:			
ICD9 Code:			
Is this claim based on an accident/injury?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Date sickness or accident/injury began:		Date first treated:	
Is condition due to injury or sickness 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:			
Fax Number:			
(Please include area code)			

**Please send the completed form to: IBEW LOCAL UNION 683 HEALTH & WELFARE PLAN
6525 Centurion Drive • Lansing, MI 48917-9275, or FAX to (517) 321-7508.**