Laborers' Metropolitan Detroit Health Care Fund

6525 Centurion Drive, Lansing, MI 48917-9275
Toll Free Telephone 1-800-228-0048
Telephone AC 517-321-7502 (out of Michigan)

STATEMENT FOR LOSS OF TIME BENEFITS
Disability Hour Credit Only

(Note: This side must be completed by you and the reverse side must be completed by your physician.)

Name_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Social Security No._____ Local Union No._____

Is this claim based on an accident/injury? Yes ☐ No ☐

If yes, is accident/injury the result if a vehicular rated accident? Yes ☐ No ☐

Nature of sickness or accident/injury_____

Date of sickness or accident/injury began_____ Date first treated_____

Did sickness or accident/injury occur in the course of any 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?_____

Have you resumed work? Yes ☐ No ☐ If yes, what date?_____

Date_____ Signature_____

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's Name_____ Date of Birth_____

Diagnosis and Concurrent Conditions_____

_____

Is this claim based on an accident/injury? Yes ☐ No ☐

Date sickness or accident/injury began_____ Date first treated_____

Is condition due to injury or sickness arising out of patient's employment? Yes ☐ No ☐

If "Yes", explain_____

Is condition due to a vehicular rated accident? Yes ☐ No ☐

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 his 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_____ next scheduled appt._____

If "No," give date treatment terminated_____

Physician's Signature_____ Date_____

Physician's Name (please print)_____ Degree_____

Address_____

City_____ State_____ Zip_____

Telephone No._____ Area Code_____