Phone: (518) 785-3440

WELFARE FUND
PLUMBERS AND STEAMFITTERS LOCAL NO.7
18 AVIS DRIVE, LATHAM, N. Y. 12110

LOSS OF TIME BENEFITS

PLEASE ANSWER ALL QUESTIONS

SECTION A – TO BE COMPLETED BY MEMBER

MEMBER'S NAME | ☐ MALE ☐ FEMALE | ☐ MARRIED ☐ SINGLE | DATE OF BIRTH | SOCIAL SECURITY NO.

HOME ADDRESS | CITY | STATE | ZIP CODE | TELEPHONE NUMBER

CURRENT OR MOST RECENT EMPLOYERS NAME AND ADDRESS

FIRST DATE UNABLE TO WORK | DATE RETURNED OR EXPECT TO RETURN TO WORK

COMPLETE IF CLAIM IS FOR INJURY:

DATE OF INJURY | TIME ☐ A. M. ☐ P. M.

DESCRIBE HOW AND WHERE ACCIDENT OCCURRED

WAS THE CLAIMENT AT WORK WHEN INJURED: ☐ YES ☐ NO | FOR WHOM? | HAVE YOU FILED FOR WORKMEN'S COMPENSATION BENEFITS: ☐ YES ☐ NO

SECTION B – PHYSICIAN'S STATEMENT

PATIENT NAME | AGE

NATURE OF SICKNESS OR INJURY (DESCRIBE COMPLICATIONS IF ANY)

GIVE DATES OF TREATMENT

HOME_____

HOSPITAL_____

OFFICE

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? IF DISCHARGED, GIVE DATE. ☐ YES ☐ NO | DATE

IF PATIENT IS HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL | HOSPITAL | CITY | STATE

DATE ADMITTED | DATE DISCHARGED

HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)? | FROM | THROUGH

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? IF "YES" EXPLAIN. ☐ YES ☐ NO

I HEREBY AUTHORIZE_____HOSPITAL(S) TO FURNISH THE WELFARE FUND, PLUMBERS & STEAMFITTERS LOCAL 7 OR THEIR REPRESENTATIVES ANY INFORMATION PERTAINING TO THIS PATIENT'S DISIBILITY OR ANY OTHER CONDITION. (A PHOTOSTAT MAY BE USED IN LIEU OF THIS ORIGINAL).

DATE_____

SIGNED_____DEGREE
(ATTENDING PHYSICIAN) M.D.

PHONE_____

(STREET ADDRESS) (CITY OR TOWN) (STATE) (ZIP)