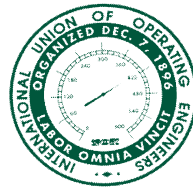


I.U.O.E. Local 4
 Health & Welfare Fund
 P.O. Box 660
 Medway, MA 02053
 Phone: 1-888-486-3524 Fax: 508-533-1404



LOSS OF TIME CLAIM FORM

SECTION A To be completed by employee

Name and home address of employee (please print) (Last Name) (Mid. Initial) (First Name)			Employer		Social Security No.		
					IUH# _____		
					Date of Birth		
Number	Street	City	State	Zip Code	Month	Day	Year

SECTION B To be completed by Physician

DIAGNOSIS AND CONCURRENT CONDITIONS
 (if diagnosis code other than ICD9 used, give name)

ICD9# _____ Description: _____

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT / WC or MVA? PREGNANCY? If Yes, approximate date pregnancy commenced.

Yes No Yes No Date _____

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED _____ DATE PATIENT CONSULTED YOU FOR THIS CONDITION _____

PATIENT EVER HAD SAME OR SIMILAR CONDITION? PATIENT STILL UNDER CARE FOR THIS CONDITION?

Yes No If yes, when and describe. Yes No

PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (unable to work)

From _____ Through _____

IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK _____ PATIENT WAS HOUSE CONFINED

DOES PATIENT HAVE OTHER HEALTH COVERAGE? PHYSICIAN'S TAX ID# (re: IRS Ruling 69-595)

Yes No If yes, please identify. _____

DATE PHYSICIAN'S NAME (PRINT) SIGNATURE DEGREE PHONE

STREET ADDRESS STATE OR PROVINCE CITY OR TOWN ZIP CODE

SECTION C To be completed by employee

I AUTHORIZE any physician, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company, or employer having information available as to diagnosis or treatment with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give to I.U.O.E. Local 4 Health & Welfare Fund or its legal representative any and all such information.

I UNDERSTAND the information obtained by use of the authorization will be used by I.U.O.E. Local 4 Health & Welfare Fund to determine insurance and eligibility for benefits under my existing policy. Any information obtained will not be released by I.U.O.E. Local 4 Health & Welfare Fund to any person or organization EXCEPT to reinsuring companies or other persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization shall be valid for the duration of the policy.

Check if you have filed a claim for WORKERS COMPENSATION, UNEMPLOYMENT, or if a THIRD PARTY or attorney is involved in this case. (Circle type of claim)

Signature

Telephone

Date