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 ICD10 used, give name)

ICD10# _____ Description:

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT S EMPLOYMENT / WC or MVA? Yes ☐ No ☐

PREGNANCY? Yes ☐ No ☐ If Yes, approximate date pregnancy commenced. Date

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED

DATE PATIENT CONSULTED YOU FOR THIS CONDITION

PATIENT EVER HAD SAME OR SIMILAR CONDITION?
Yes ☐ No ☐ If yes, when and describe.

PATIENT STILL UNDER CARE FOR THIS CONDITION?
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

From _____ Through _____

DOES PATIENT HAVE OTHER HEALTH COVERAGE?
Yes ☐ No ☐ If yes, please identify.

PHYSICIAN'S TAX ID# (re: IRS Ruling 69-595)

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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 PA RT Y or attorney is involved in this case. (Circle type of claim)

_____
Signature

_____
Telephone

_____
Date