LOSS OF TIME STATEMENT OF CLAIM ACCIDENT OR SICKNESS

RETURN THIS COMPLETED FORM TO:
WESTERN PENNSYLVANIA TEAMSTERS AND EMPLOYER WELFARE FUND
50 Abele Road, Suite 1005, Bridgeville, PA 15017
Telephone: 412-363-2700 - Toll Free: 800-242-0410 - Facsimile: 412-363-0580
Email: kceoffe@wpawelfarefund.com

IMPORTANT - Claims SHOULD Be Filed Within 20 Days After Commencement of Disability

EMPLOYEE COMPLETES IN ALL CASES

Phone # _____

1. Name of Employee: _____ SSN _____
2. Home Address: _____ Date of Birth: _____
   No. and Street City State Zip
3. Employed by _____ Occupation _____
4. **IF AN ACCIDENT WAS INVOLVED, A SUBROGATION FORM IS TO BE COMPLETED AS WELL**
   (a) When did the accident happen? Date _____ Time _____ ☐ a.m. ☐ p.m.
   (b) Were you at work when the accident happened? Yes ☐ No ☐
   (c) Give a brief description of the accident _____
5. On what date were you first totally disabled by the sickness or injury? _____
6. On what date were you first treated by a physician? _____
7. Have you returned to work? Yes ☐ No ☐ (a) If so, on what date? _____ (b) If not, when do you expect to return to work? _____

☐ **I agree to notify the Welfare Fund if I receive Workers Compensation, Unemployment Compensation, or if my employment readiness status changes, for instance, retirement or other termination of employment.**

By signing this form, I hereby certify that the foregoing statements, including any accompanying statements are to the best of my knowledge and belief true, correct and complete, and I agree to refund any overpayment, or amount subject to subrogation, that may be made to me on this claim. I hereby authorize any physician, or any hospital, to furnish and disclosed records and all known facts concerning this disability to the Fund Office. A copy of this authorization shall be as valid as the original.

Date this Claim Form Signed _____ Employee's Signature _____ **X** **EMPLOYEE SIGN HERE**

EMPLOYER MUST COMPLETE THIS SECTION WHEN EMPLOYEE IS APPLYING FOR LOSS OF TIME BENEFITS

Date last worked _____ Has a Workers Compensation Claim been made? Yes ☐ No ☐
Date returned to work _____ If not, what is present status? _____
Is employee receiving any wages, vacation or sick pay while off? Yes ☐ No ☐ If "Yes", please provide the days _____
Does FMLA Policy require use of vacation or sick days? Yes ☐ No ☐
Date signed _____ Employer's Signature _____ Phone # _____

ATTENDING PHYSICIANS' STATEMENT

1. DIAGNOSIS OR CURRENT CONDITION

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S WORK? YES ☐ NO ☐

3. REPORT OF SERVICES

DATE OF SERVICES	PLACE OF SERVICES+	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED

+ Place of Service Codes:

O - Doctor's Office IH - Inpatient Hospital NH - Nursing Home
H - Patient's Home OH - Outpatient Hospital LO - Other Locations

4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.

5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

6. PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES ☐ NO ☐

PATIENT HOSPITALIZED:
from thru

7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐

8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)
from thru

9. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

DATE PHYSICIAN'S NAME (PRINT) SIGNATURE PHONE NUMBER

STREET ADDRESS CITY OR TOWN STATE OR PROVINCE ZIP CODE