MICHIGAN LABORERS' HEALTH CARE FUND

6525 Centurion Drive
Lansing, MI 48917
Toll Free: (877) 645-2267

STATEMENT FOR LOSS OF TIME BENEFITS

(Note: Participant must complete this side
Reverse side must be completed by your physician)

Name:	Date of Birth:
Street Address:	
Member ID or Social Security #:	Local Union #:
Is this claim based on an accident/injury?	Yes ☐ No ☐
Nature of sickness or accident/injury:	
Date sickness or accident/injury began:	Date first treated:
Did sickness or accident/injury occur in the course of 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:	
Are you retired? Yes ☐ No ☐	Are you receiving Social Security Disability? Yes ☐ No ☐
Signature:	Date:

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ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's Name:	Member Identification #:	Date of Birth:
Diagnosis and Concurrent Conditions:		
ICD9 Code:		
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: Erase and type over this text. Press <ENTER> to start a new line within this box.		
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 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:		
If YES, give date of next scheduled appointment:		
If NO, give date treatment terminated:		
Physician's Signature:	Date:	
Physician's Name (please print)	Degree:	
Address:		
Telephone Number:	Fax Number:	