MO-KAN SHEET METAL WORKERS WELFARE FUND

P.O. Box 300019
Kansas City, Missouri 64130-0019
Phone: 816-531-0334

LOSS OF TIME

ACTIVE ☐ RETIRED ☐

EMPLOYEE COMPLETES

1. EMPLOYEE S NAME First	Last	2. SEX	3. BIRTHDATE Mo. Day Yr.	4. EMPLOYEE S SOC. SEC. #
5. EMPLOYEE S ADDRESS Number	Street	6. HOME PHONE:		
7. City	State Zip Code			

8. EMPLOYED BY ADDRESS:	LOCAL #	9. Date last worked	10. Date returned to work

11. IS CONDITION RELATED TO:
- A. PATIENT S EMPLOYMENT ☐YES ☐NO
- B. AN AUTO ACCIDENT ☐YES ☐NO
- C. ANY OTHER ACCIDENT ☐YES ☐NO

12. IF RELATED TO AN ACCIDENT
DATE _____
WHERE _____
HOW _____

I certify that the above statements are correct and hereby authorize any doctor or organization to provide pertinent records to MO-KAN Sheet Metal Workers Welfare Fund upon request.

EMPLOYEE SIGNATURE ➡ _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

DOCTOR COMPLETES

13. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT OR PREGNANCY (LMP)	14. DATE FIRST CONSULTED YOU FOR THIS CONDITION	15. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO
16. DATE PATIENT ABLE TO RETURN TO WORK	17. DATES OF TOTAL DISABILITY FROM THROUGH	18. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
19. NAME OF REFERRING PHYSICIAN OF OTHER SOURCE (e.g., PUBLIC HEALTH AGENCY)		20. WAS CONDITION RELATED TO PATIENT S EMPLOYMENT? YES NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.

1.
2.
3.
4.

I certify that I personally rendered the above services, and that the amounts shown as Fee Charged are the fees that I personally charged the Subscriber and that they are my usual fees for such services.

DOCTOR S SIGNATURE ➡ _____

DOCTOR'S ADDRESS (PLEASE PRINT)

22. TELEPHONE NO.

23. SS# OR TAX ID#

24. DOCTOR'S PRINTED NAME & CREDENTIALS

CLM 3896

FILING INSTRUCTIONS

LOSS OF TIME

1. Complete the Employee's (upper) portion of the form.
2. Have your physician complete his portion of the form in its entirety. Any unanswered questions may cause a delay in the payment of benefits.
3. Send the claim form to the address noted below as soon as possible so that we may begin your loss of time benefit.

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Mail to:

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