

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 <input type="checkbox"/> YES <input type="checkbox"/> NO B. AN AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO C. ANY OTHER ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>
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.		22. TELEPHONE NO. _____
DOCTOR S SIGNATURE _____ DOCTOR'S ADDRESS (PLEASE PRINT) _____		23. SS# OR TAX ID# _____
		24. DOCTOR'S PRINTED NAME & CREDENTIALS _____

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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