

MOKAN SHEET METAL WORKERS WELFARE FUND

P.O. Box 300019
Kansas City, Missouri 64130-0019
Ph #: 816-531-0334
Fax #: 816-753-7252

CONTINUATION FOR LOSS OF TIME BENEFITS FORM
Member and Physician must complete this form in full

CLAIMANT'S STATEMENT (MEMBER)

Name _____

Address _____

SS# _____

Have you filed or do you intend to file for workers' compensation? _____

Have you applied for Social Security Disability and/or Disability Pension? _____

Have you returned to work? _____ Yes _____ No If so, when? _____

If not, when do you expect to be able to return to work? _____

Date _____ Signed _____ Member

ATTENDING PHYSICIAN OR SURGEON'S STATEMENT

Nature of sickness or injury _____

To your knowledge has the patient filed or intend to file for workers' compensation? _____

Patient has been totally disabled _____ Date of next appointment _____

From _____, 20____

Through _____, 20____

If still disabled, when should patient be able to return to work? _____

Date _____

Signed _____

Printed Name _____
(Physician)

Address _____

Telephone _____