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 ____________________

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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 ____________________