Indiana Teamsters Health Benefits Fund
6007 S. Harding Street Indianapolis, IN 46217
Phone 317-639-3573 Fax 317-639-3580

FOR OFFICE USE ONLY - DO NOT WRITE ABOVE THIS LINE

LOSS OF TIME CLAIM FORM

IMPORTANT NOTICE: Benefits will be authorized providing the member is eligible and contributions have been made according to the provisions of the group plan.

SECTION 1 EMPLOYEE'S STATEMENT (PLEASE PRINT)

Employee's Name _____ Social Security # _____

Street Address _____ City & State _____ Zip Code _____

Has address changed since last claim? ☐ Yes ☐ No Date of birth _____

Telephone # _____ Employer _____

Was this disability in any way job related? ☐ Yes ☐ No Was this disability due to an accident? ☐ Yes ☐ No

If an accident, state: Date of accident _____
Where it occurred _____
How it occurred _____

If an illness, ***explain nature of illness*** _____

I herby certify that the above information is true, correct and complete and authorize any provider, insurance company, or their representative to furnish and disclose all known facts.

Date _____ Signature _____

SECTION 2 STATEMENT MUST BE FROM MEDICAL DOCTOR

Patient's Full Name _____

Date disability began _____ Date patient will be able to return to work _____

If uncertain of exact return-to-work date, give approximate duration of disability _____

Date patient to return for re-check _____ Date first examined for this disability _____

Date illness began _____ All dates of service for this disability _____

Nature of illness or injury _____

Primary Diagnosis code _____ ***Provide*** **supporting medical documentation for this diagnosis**
Form will not be processed without medical documentation

If any complications, please explain _____

Is illness or injury due to patient's employment or occupation in any way ☐ Yes ☐ No

If yes, please explain _____

I herby certify that the above information is true, correct and complete and authorize Local 135 Health Benefits fund or its representatives to examine all records pertaining to this patient.

Date _____ Doctor's Signature _____ Credentials _____

Printed Name _____ Tax ID or S.S. # _____ Telephone # _____

Street Address _____ City & State _____ Zip Code _____

SECTION 3 EMPLOYER'S STATEMENT

Date employee last worked prior to this disability _____

Is employee on vacation ☐ Yes ☐ No If yes, give date _____
Is employee on layoff ☐ Yes ☐ No If yes, give date _____
Is employee terminated ☐ Yes ☐ No If yes, give date _____
Is employee retired ☐ Yes ☐ No If yes, give date _____

Has employee filed a claim for workmen's compensation benefits? ☐ Yes ☐ No
Is this disability in any way job related? ☐ Yes ☐ No If employee has returned to work, give date _____

I herby certify that the above information is true, correct and authorize Local 135 Health Benefits Fund or its representatives to examine all records pertaining to this employee.

Date _____ Signature _____ Telephone # _____
Print Name _____ Title _____ Company _____

Street Address _____ City & State _____ Zip Code _____

All fields must be completed to process this form Date Processed _____

Email to: ITHBFMEMBER@LOCAL135.COM