Revised 05/2023

INDIANA LABORERS WELFARE FUND
P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587
Telephone (812) 238-2551 Toll Free 1-800-962-3158
Fax (812) 238-2553 www.indianalaborers.org

LOSS OF TIME
CONTINUATION OF BENEFITS APPLICATION

*Application must be filed within 18 months or eligibility will be denied.
*All questions must be answered in order to prevent a delay in benefit payment.

(To be completed by Member)

Name _____ SSN or Member ID# _____

Mailing Address (street, city, state, zip) _____ Phone Number _____

Have you returned to work? **Yes** (if yes, please provide date)_____ **No**_____

Have you applied for or are you receiving Worker's Compensation benefits? **Yes**_____ **No**_____

Have you received Unemployment Insurance Benefits during any period for which you have claimed Loss of Time Benefits?
Yes_____ **No**_____

I hereby certify that the foregoing statements, including any accompanying statements, are true, correct and complete to the best of my knowledge and hereby further authorize my attending physician, practitioner or hospital in which confinement took place to furnish and disclose all facts concerning my physical condition that are within their knowledge.

Member's Signature_____ Date_____

(To be completed by Provider: Please provide as much detailed information as possible, <u>including ICD10 or Surgery Codes</u> in order to avoid delay and allow accurate payment of benefits to this patient).

ICD10 Code(s) with description: _____

Surgical Code(s):_____

Dates of Treatments Since Last Report: Office Visit(s)_____

Hospital_____(specify inpatient, outpatient or ER)

Home/Phone Consultation_____

Patient has been continuously disabled (unable to work) beginning: _____

Dates of Total Disability: From_____ Through_____

Anticipated return to work date: _____
If you return to work without a release from the Physician that date would be considered the release date.

List Any/All Restrictions: _____

Printed name of Doctor _____ Phone number _____ Fax number _____

Doctor's signature _____ Date _____