RETURN THIS FORM TO:

CENTRAL LABORERS' WELFARE FUND
P. O. BOX 1267 • JACKSONVILLE, ILLINOIS 62651

STATEMENT OF CLAIM FOR
LOSS OF TIME

This report should be completed immediately

Employer No. _____

PART 1 – EMPLOYEE COMPLETES IN ALL CASES

1. Employee's Name (Print) _____ Social Security No. _____
2. Present Address _____
   (Number) (Street) (City) (State) (Zip Code)
3. Employee's Birth Date _____ Sex ____ Telephone Number _____ Local Union # _____
4. Is disability due to accident or sickness? State which: _____
5. Was the disability a result of your employment? Yes ___ No ___
6. On what date did you cease working? Date _____ at _____ (hr) am ____ pm ___
7. For whom were you working at the time you became disabled? _____
8. On what date did you, or do you expect to resume full/part time work?
   Date _____ Duties resumed _____
9. IF AN ACCIDENT WAS INVOLVED, ANSWER THE FOLLOWING:
   (a) When did the accident happen? Date _____ at _____ (hr) am ____ pm ___
   (b) Were you performing the duties of your occupation when the accident happened? Yes ___ No ___
   (c) Give a brief description of the accident: _____
   _____
   _____

PART 2 – COMPLETE IN ALL CASES

I hereby certify the statements hereon and attached are complete and accurate and I authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, government agency, insurance company or employer to disclose any knowledge or information which is material to the processing of this claim to The Central Laborers' Welfare Fund, P. O. Box 1267, Jacksonville, Illinois 62651. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date _____ Employee's Signature _____

THE ATTENDING PHYSICIAN MUST COMPLETE THE REVERSE SIDE OF THIS FORM

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Note: No Benefits can be paid until this form is completed and returned to the Central Laborers' Welfare Fund, P. O. Box 1267, Jacksonville, Illinois 62651

Patient's Name _____

Diagnosis and Concurrent Conditions _____

_____

Did the illness or injury arise out of the patient's employment? Yes ___ No ___

Date of First Treatment _____

Date of Most Recent Treatment _____

Frequency of Treatments _____

The Patient has been Continuously Disabled (Unable to Work) From _____ through _____

Date Total Disability Terminated _____

If still Disabled, When should Patient be able to return to Work? _____

Remarks: _____

_____

Signed _____ Degree

Date _____ Address _____