ELECTRICAL WORKERS BENEFIT TRUST FUND
Local Union #481, IBEW
1828 N. Meridian Street, Suite 103
Indianapolis, IN 46202-1452
(317) 923-4577, Fax: (317) 923-7633
email: info@ewbtf.org

STATEMENT OF CLAIM FOR LOSS-OF-TIME BENEFITS

Insured's Statement

1. Insured's Name ____
2. Insured's Social Security Number ________________________________
3. Insured's Address ____

   ____

Date ____________________ Signature of Insured __________________________

Attending Physician's Statement

1. Patient's Name ____
2. Nature of illness or injury (and complications, if any) ______________________

   ____

3. Is the patient presently under your care for this condition? ☐ YES ☐ NO
4. Date of injury or first symptoms ____________________

   Date of first examination ________________________

   Date of next scheduled examination _______________

5. The patient is: ☐ Ambulatory ☐ Ambulatory with Aid ☐ Wheelchair Confined ☐ House Confined ☐ Bed Confined ☐ Hospital Confined
6. The patient has been unable to work from ______________ through ______________.
7. When should the patient be able to return to work (estimated)? __________________
8. If indefinite, in order to minimize paperwork, please give an estimated time of disablement from the present date. ____________________________

Restrictions ____

Date ______________ Signature of Physician ________________________________

Address of Physician ______________________________________

Phone # ______________ ______________________________________