



Application for Loss of Time Benefits

Please fill out completely by typing or printing in ink.

To receive your Loss of Time Benefit, this form must have all three parts completed. Upon submission, your claim will be reviewed to determine available benefits. Failure to complete any part of this form may delay payment of your benefits.

YOU MUST INFORM US OF YOUR RETURN TO WORK DATE AND PROVIDE WISCONSIN HEALTH FUND WITH A PHYSICIAN RELEASE FORM

PART A: TO BE COMPLETED BY THE COVERED MEMBER CLAIMING BENEFITS

Name of Member: _____

Member's ID Number: _____

Address: _____
Number and street City State Zip

Phone Number: _____ Date of Birth: _____ Sex: _____

Name of Employer: _____

A. If disability is due to an ILLNESS, complete the following:

Description of illness: _____

Did the illness arise in the course of your employment? Yes _____ No _____

If yes, explain: _____

B. If disability is due to an ACCIDENT or INJURY, complete the following:

Description of accident or injury: _____

Where did the accident or injury occur? _____

Approximate time and date of accident or injury: _____

Did the accident or injury arise in the course of your employment? Yes _____ No _____

If yes, explain: _____

I hereby certify that the above statements, including any accompanying statements, are true and complete to the best of my knowledge and belief. I authorize any physician or hospital to furnish and disclose all known facts concerning this disability. A copy of this authorization shall be as valid as the original.

Member's Signature _____

Date _____

Application continues on reverse.

