Application for Loss of Time Supplement

Please fill out completely by typing or printing in ink

To continue receiving your Loss of Time Benefit, this form must be completed by your attending physician. Upon submission, your claim will be reviewed to determine additional benefits.

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

Name of Employer: _____

PART B: TO BE COMPLETED BY ATTENDING PHYSICIAN (at no expense to WHF)

Diagnosis (describe complications, if any):_____

_____

Date of most recent treatment: _____

Frequency of treatments: _____

Patient has been continuously disabled or unable to work FROM: _____ TO: _____

If still disabled, when should patient be able to work? _____

Remarks: _____

_____

_____ _____ _____
Physician's signature Date Signed Tax ID Number

_____ _____ _____
Physician's name (please print) Degree Telephone Number

Address: _____
Number and Street City State Zip

Note: This form needs to be received by Wisconsin Health Fund in a timely manner. We do not accept faxes. All parts of this form must be completed to assure validity and to provide benefits. Please send completed forms to Wisconsin Health Fund, Loss of Time, 1314 N. Stoughton Rd., Madison, WI 53714. If you have any questions regarding this form, call WHF Customer Service at 1-888-208-8808.

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