# 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 Apt# 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: _____

Is this illness work related? 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: _____

Is this accident or injury work related? 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. I agree to contact WHF every Friday to verify I am still off of work, I realize failure to do so may result in a suspension of my Loss of Time benefit.**

_____ _____
Member's Signature Date

*Application continues on reverse*

## **PART B:** TO BE COMPLETED BY THE EMPLOYER

Is the illness/accident/injury work related? If yes, explain_____

_____

First full day unable to work:_____ Last day physically worked:_____

Date returned to work: _____

Date expected to return to work: _____

_____ _____ (____)_____

Authorized signature and title Date signed Telephone number

## **PART C:** TO BE COMPLETED BY ATTENDING PHYSICIAN (at no expense to WHF)

Diagnosis (describe complications, if any): _____

_____

Is this illness/accident/injury work related? Yes _____ No _____

If yes, explain: _____

Date of illness/accident/injury: _____ Date of first treatment: _____

Date of most recent treatment: _____ Frequency of treatments:_____

Surgical procedure(s): _____

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

If still disabled, when should patient be able to return 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: Original form needs to be returned to Wisconsin Health Fund, copies of this form will be accepted until the original is received. 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, 6200 W. Bluemound Rd., Milwaukee, WI 53213. If you have any questions regarding this form, call WHF Customer Service at 1-888-208-8808.**