MO-KAN SHEET METAL WORKERS WELFARE FUND

P.O. Box 300019
Kansas City, Missouri 64130-0019
Phone: 816-531-0334
Fax: 816-753-7252

LOSS OF TIME

EMPLOYEE COMPLETES

1. EMPLOYEE S NAME First	Last	2. SEX	3. BIRTHDATE Mo. Day Yr.	4. EMPLOYEE S SOC. SEC. #
5. EMPLOYEE S ADDRESS Number	Street	6. HOME PHONE:		
7. City	State Zip Code	____Member Illness/Injury ____Member Maternity Leave ____Paternal Leave		
8. EMPLOYED BY ADDRESS:		LOCAL #	9. Date last worked	10. Date returned to work

11. IS CONDITION RELATED TO:
- A. PATIENT S EMPLOYMENT ☐YES ☐NO
- B. AN AUTO ACCIDENT ☐YES ☐NO
- C. ANY OTHER ACCIDENT ☐YES ☐NO

12. IF RELATED TO AN ACCIDENT
DATE _____
WHERE _____
HOW _____

I certify that the above statements are correct and hereby authorize any doctor or organization to provide pertinent records to MO-KAN Sheet Metal Workers Welfare Fund upon request.

EMPLOYEE SIGNATURE ➡ _____

Dates Requested for Paternal Leave: From _____through_____
(Please note there is a 2 week maximum allowance. 1 week maximum for vaginal birth or placement for adoption or foster care and 2 weeks maximum for cesarean section birth)

Delivery Type _____Vaginal _____Cesarian section

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

DOCTOR COMPLETES

13. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT OR PREGNANCY (LMP)	14. DATE FIRST CONSULTED YOU FOR THIS CONDITION	15. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ ☐ NO
16. DATE PATIENT ABLE TO RETURN TO WORK	17. DATES OF TOTAL DISABILITY FROM / THROUGH	18. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED / DISCHARGED
19. NAME OF REFERRING PHYSICIAN OF OTHER SOURCE (e.g., PUBLIC HEALTH AGENCY)		20. WAS CONDITION RELATED TO PATIENT S EMPLOYMENT? YES ☐ ☐ NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.

1.
2.
3.
4.

I hereby certify that all the information in the section is accurate and complete to the best of my knowledge.

DOCTOR'S SIGNATURE ➡ _____

DOCTOR'S ADDRESS (PLEASE PRINT)

22. TELEPHONE NO.

23. SS# OR TAX ID#

24. DOCTOR'S PRINTED NAME & CREDENTIALS (DOCTOR MUST BE A M.D. or D.O.)