FLINT PLUMBING AND PIPEFITTING INDUSTRY INSURANCE FUND

6525 Centurion Drive
Lansing, Michigan 48917-9275
Telephone: 517-321-7502
Toll Free 888-797-5862

STATEMENT FOR LOSS OF TIME BENEFITS

(Note: This side must be completed by you and your employer
and the reverse side must be completed by your physician)

Name:		Date of Birth:	
Address:	City:	State:	Zip:
Member Id or SS#:		Local Union #:	
Is this claim based on an accident/injury?		Yes ☐	No ☐
Nature of sickness or accident/injury:			
Date sickness or accident/injury began:	Date first treated:		
Did sickness or accident/injury occur in the course of employment?		Yes ☐	No ☐
Where did sickness or accident/injury occur?			
How did sickness or accident/injury happen?			
Have you, or do you intend to file this claim under Workers' Compensation?		Yes ☐	No ☐
On what date did you last work?			
Have you resumed work?		Yes ☐	No ☐
If YES, what date:			
Are you Retired Yes ☐ No ☐	Are you receiving Social Security Disability? Yes ☐ No ☐		
Signature:		Date:	

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ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's Name: Member ID or SS #:		Date of Birth:	
Diagnosis and Concurrent Conditions: ICD9 Code:			
Is this claim based on an accident/injury?		Yes	No
Date sickness or accident/injury began:	Date first treated:		
Is condition due to injury or sickness arising out of patient's employment?		Yes	No
If YES, explain:			
This patient has been continuously disabled (first day unable to work) from _____ through (last day unable to work)_____.			
Exact date patient will be able to return to work at trade:			
If exact date is unknown, please estimate:			
Is patient still under your care for this condition?		Yes	No
If YES, give date of last treatment:			
If YES, give date of next scheduled appointment:			
If NO, give date treatment terminated:			
Physician's Signature:		Date:	
Physician's Name (please print)		Degree:	
Address:			
City:	State:	Zip:	
Telephone Number:			