PLUMBING AND PIPEFITTING INDUSTRY
HEALTH AND WELFARE FUND OF KANSAS
505 S. BROADWAY, SUITE 117
WICHITA, KANSAS 67202-3922
PHONE (316) 264-2339
FAX (316) 264-9245
JOE D. PUCCI, ADMINISTRATOR

INITIAL REPORT FOR GROUP LOSS OF TIME BENEFITS

THIS SECTION TO BE COMPLETED BY INSURED MEMBER

MEMBER'S FULL NAME		DATE OF BIRTH		SOCIAL SECURITY #
ADDRESS	**CITY**	**STATE**	**ZIP CODE**	**AREA CODE - PHONE #**
DATE YOU WERE FIRST UNABLE TO WORK		DATE YOU RETURNED TO WORK (IF APPLICABLE)		

WAS DISABILITY WORK RELATED? YES ☐ NO ☐	HAS THERE BEEN, OR WILL THERE BE, A CLAIM FILED FOR THIS DISABILITY WITH A WORKMAN'S COMPENSATION CARRIER? YES ☐ NO ☐	
IF YOU WERE INJURED ⟹	DATE ACCIDENT OCCURRED?	TIME ACCIDENT OCCURRED?
WERE YOU AT WORK WHEN ACCIDENT OCCURRED? YES ☐ NO ☐	DESCRIBE THE ACCIDENT	

DESCRIBE THE DISABILITY

NAME & ADDRESS OF CURRENT EMPLOYER

I HEREBY CERTIFY THE STATEMENTS HEREON & ATTACHED ARE COMPLETE & ACCURATE.
I AUTHORIZE ANY PERSON OR INSTITUTION RENDERING CARE OR ANY PERSON OR ORGANIZATION IN POSSESSION OF INSURANCE OR OTHER BENEFIT INFORMATION CONCERNING ME, TO FURNISH OR DISCLOSE ALL KNOWN FACTS CONCERNING THIS DISABILITY. A COPY OR PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
IF MY CLAIM IS ACCEPTED AS VALID AND IF THE PLAN SHOULD DECIDE IT IS NECESSARY, I AGREE TO A PHYSICAL EXAMINATION BY A PHYSICIAN OF THE ADMINISTRATOR'S CHOOSING, AS A PREREQUISITE TO FURTHER LOSS OF TIME BENEFITS.

DATE	EMPLOYEE'S SIGNATURE

` **OPPOSITE SIDE TO BE COMPLETED BY ATTENDING PHYSICIAN**

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ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME	DOB

DIAGNOSIS AND CURRENT CONDITIONS

DATE & DESCRIPTION OF SURGICAL PROCEDURES

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?

☐ YES ☐ NO

DATES OF SERVICES AND OFFICE VISITS

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT OCCURRED:	DATE PATIENT FIRST CONSULTED YOU FOR THIS:
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO	IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO

PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK):

FROM: TO:

PATIENT WAS PARTIALLY DISABLED:

FROM: TO:

IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:	WERE YOU THE FIRST PHYSICIAN TO TREAT THE PATIENT FOR THIS CONDITION? ☐ YES ☐ NO
PHYSICIAN'S NAME (PLEASE PRINT)	PHYSICIAN'S SS# OR EMPLOYER ID#

ADDRESS	CITY	STATE	ZIP CODE	AREA CODE-PHONE #

PHYSICIAN'S SIGNATURE	DEGREE	DATE