

**PLUMBING AND PIPEFITTING INDUSTRY
HEALTH AND WELFARE FUND OF KANSAS**

505 S. BROADWAY, SUITE 117
WICHITA, KANSAS 67202-3922

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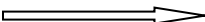
PAULA URTON, ADMINISTRATOR

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 <input type="checkbox"/> NO <input type="checkbox"/>	HAS THERE BEEN, OR WILL THERE BE, A CLAIM FILED FOR THIS DISABILITY WITH A WORKMAN'S COMPENSATION CARRIER? YES <input type="checkbox"/> NO <input type="checkbox"/>
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IF YOU WERE INJURED 	DATE ACCIDENT OCCURRED?	TIME ACCIDENT OCCURRED?
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WERE YOU AT WORK WHEN ACCIDENT OCCURRED? YES <input type="checkbox"/> NO <input type="checkbox"/>	DESCRIBE THE ACCIDENT
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DESCRIBE THE DISABILITY

NAME & ADDRESS OF CURRENT EMPLOYER

LOCAL UNION 441

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? <input type="checkbox"/> <input type="checkbox"/> <div style="display: flex; justify-content: space-around; width: 100%;"> YES NO </div>				
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? <input type="checkbox"/> <input type="checkbox"/> <div style="display: flex; justify-content: space-around; width: 100%;"> YES NO </div>			IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> <input type="checkbox"/> <div style="display: flex; justify-content: space-around; width: 100%;"> YES NO </div>	
PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK): 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? <input type="checkbox"/> <input type="checkbox"/> <div style="display: flex; justify-content: space-around; width: 100%;"> YES NO </div>	
PHYSICIAN'S NAME (PLEASE PRINT)			PHYSICIAN'S SS# OR EMPLOYER ID#	
ADDRESS	CITY	STATE	ZIP CODE	AREA CODE-PHONE #
PHYSICIAN'S SIGNATURE			DEGREE	DATE