Electrical Workers Health and Welfare Fund
2002 London Road, Suite 300
Duluth, Minnesota 55812

Telephone: *(218) 724-8883*
Toll Free: *(877) 908-3863*
Fax: *(218) 728-4773*

Statement of Claim for Weekly Time Loss Benefits

Claimant's Statement

The claimant must complete all parts of the following statement

I hereby apply for benefits on aacount of disability.

1. Name: ______________________ Date of Birth: ______________
   Address: ______________________ Phone Number: ______________
2. On whate date did you last work? ______________________
3. On what date were you first disabled? ______________________
4. Cause of disability *(if due to accident, **when**, **where** and **how** did it happen)*. ______________________
5. If you have returned to work, on what date did you return? ______________________
6. If you have not returned to work, on what date do you expect to? ______________________
7. Have you filed, or do you intend to file, claims for benefits under any Workmen's Compensation Act? Yes ☐ No ☐

Name of Employer: ______________________
Address: ______________________

______________________ ______________________
Claimant's Signature *Date*

Attending Physician's Statement

1. Patient's Name: ______________________ Age: ______________
2. Nature of illness or injury *(describe complications, if any)*: ______________________
3. Did this illness or injury arise out of patient's employment? Yes ☐ No ☐
   If "Yes," please explain: ______________________
4. Nature of surgical procedure, if any *(describe fully)*: ______________________
5. Date of first treatment for this disability: ______________________
6. The patient has been continuously disabled *(unable to work)* from ______________ Through ______________
   If still disabled, when should patient be able to return to work? ______________________

Remarks ______________________

Name of Physician: ______________________
Address: ______________________

______________________ ______________________
Physician'sSignature *Date*