Return Complete Form To:
WISCONSIN LABORERS' HEALTH FUND
4633 LIUNA WAY, SUITE 201
DEFOREST, WISCONSIN 53532
Telephone: (608) 846-1742 Toll Free: (800) 397-3373 Fax: (608) 846-3224

# STATEMENT OF CLAIM
# FOR ACCIDENT AND SICKNESS WEEKLY BENEFITS

**INSTRUCTIONS**: This form must be submitted by the individual claimant to the office of the Claim Administrator properly and fully completed and signed by claimant and the attending physician.

| Member's Full Name | Sex ☐ Male ☐ Female<br>Telephone No. |
|---|---|
| Social Security Number | Date of Birth |

Home Address *Street, City, Zip Code*

| First full day unable to work | Describe Illness or Injury |
|---|---|
| Date of first medical attention for this condition | |

| Is member claiming or receiving workmen's compensation benefits?<br>☐ Yes ☐ No | *If "Yes" to previous question*, What is the present status of the compensation claim? |
|---|---|

| Are you totally disabled by this illness or injury?<br>☐ Yes ☐ No | Are you now unable to physically engage in any work, occupation or business?<br>☐ Yes ☐ No |
|---|---|

Have you returned to work?

☐ Yes *Provide date returned to work:*_____
☐ No *Date expected to return to work:*_____

**If released to light-duty work, please forward written confirmation from employer or union if no light-duty work is available.

| Name of Employer | Telephone No. |
|---|---|

**I HEREBY AUTHORIZE the physician to release information requested with respect tot his claim. I certify that the information furnished by me in support of this claim is true and correct. I know it is unlawful to fill out this form with facts that I know are false or to leave out facts I know are important.**

Signature of Employee Date Signed

**OPPOSITE SIDE IS FOR ATTENDING PHYSICIAN'S REPORT**

# ATTENDING PHYSICIAN'S STATEMENT

| Patient's Name | Age |
|---|---|
| | |

Nature of sickness or injury. *Describe complications, if any:*

Did this sickness or injury arise out of patient's employment?

☐ Yes ☐ No

*If "Yes", explain:*

| Date of First Treatment | Date of Most Recent Treatment | Frequency of Treatments | Next Appointment Date |
|---|---|---|---|
| | | | |

The patient has been continuously disabled (unable to work):

*From:* *Through:*

*If still disabled*, when should patient be able to return to work?
*Please project a date, if possible.*

Is this person under your professional care at present?

☐ Yes ☐ No

Remarks

| Physician's Name **Type or Print** | Degree | Telephone |
|---|---|---|
| | | |

| Signature of Attending Physician | Date Signed |
|---|---|
| | |

Address *Street, City, State, Zip Code*

| Individual Practitioner – Social Security Number | All Others – Employer I.D. No. *Must be furnished under authority of law.* |
|---|---|
| | |