Loss of Time Benefit Form

(Short-Term Disability)

Operating Engineers Local 139 Health Benefit Fund
N27 W23233 Roundy Drive, P O Box 160, Pewaukee, WI 53072-0160
262-549-9190 or toll free 800-242-7018, Fax 262-549-3549

This form must be completed and signed by the participant and the physician. Benefits may be delayed and the form will be returned for incomplete information or missing signatures.

Participant Information (IUOE member)

Print Participant's Last Name:	First Name:	Date of Birth:	
Address Street Number:	City:	State:	Zip:
Social Security Number or OEF Number:		Birth Date (MM/DD/YY):	
Home Phone Number: ( )		Cell Phone Number: ( )	
Last Day Worked (month, day, and year):		Date Returned to Work (month, day, and year):	
Type of Sickness or Injury:	Date of Accident or Sickness Began:	Date First Treated (month, day, and year):	
Name and address of Physician:			
If Hospitalized, Name of Hospital:		Date Admitted:	Date Discharged:
If injured, how and where did the accident happen?			
Did injury occur in the course of any employment: Yes ☐ No ☐	If your disability is **permanent**, have you applied for disability benefits from Social Security or from Central Pension? Yes ☐ No ☐		
Authorization to release information: I authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.	**Participant's signature:**	**Date:**	

Attending Physician Statement

Diagnosis and concurrent Conditions:		
Is condition due to injury or sickness arising out of the patient's employment? Yes ☐ No ☐	Comments:	
Report of services provided: Date of Service: _____ Description of service or treatment: _____ _____ _____		
Date symptoms first appeared or accident happened:	Date patient first consulted you for this condition:	Patient still under your care: Yes ☐ No ☐
Patient was continuously totally disabled (Unable to work): From: To:	If still disabled, date patient should be able to return to work:	If return to work date is unknown, list approximate number of weeks:
Physician's Name (please print):	Physician's Address:	
Physician's signature:	Physician's telephone number:	