PLUMBERS AND PIPEFITTERS LOCAL NO. 333

16180 NATIONAL PKWY
LANSING, MI 48906
(STD & Sub Fund Office)
(517) 323-0333 • Fax (517) 323-0338
Or
(Lansing Local 333 Hall)
(517) 393-5480 • Fax (517) 393-0798

STATEMENT FOR LOSS OF TIME BENEFITS

(Note: Participant must complete this side
***Reverse side must be completed by your physician*)**

Name:		Date of Birth:	
Address:	City:	State:	Zip:
Social Security # and/or BCBS ID#:			
Home Phone #:	Cell Phone #:		
Name and Address of last Employer:			
Is this claim based on an accident/injury?		Yes ☐	No ☐
Date sickness or accident/injury began:		Date first treated:	
Did sickness or accident/injury occur in the course of employment?		Yes ☐	No ☐
Where did sickness or accident/injury occur?			
How did sickness or accident/injury happen?			
If Hospitalized, Name of Hospital:	Admitted:	Discharged:	
Was surgery performed? If yes, give date: And nature of surgery:		Yes ☐	No ☐
Have you, or do you intend to file this claim under Workers' Compensation?		Yes ☐	No ☐
On what date did you last work?			
Have you resumed work?		Yes ☐	No ☐
If YES, what date:			
Are you Retired? Yes ☐ No ☐	Are you receiving Social Security Disability? Yes ☐ No ☐		
Signature:		Date:	

PLUMBERS AND PIPEFITTERS LOCAL NO. 333
ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's Name: Member ID or SS #:	Date of Birth:

Diagnosis and Concurrent Conditions:
ICD9/10 Code:

Is this claim based on an accident/injury?	Yes ☐	No ☐

Date sickness or accident/injury began:	Date first treated:

Is condition due to injury or sickness arising out of patient's employment?	Yes ☐	No ☐

If YES, explain:

Is condition due to pregnancy? If Yes, approximate date pregnancy commenced:	Yes ☐	No ☐

This patient has been continuously disabled (first day unable to work) from _____ through (last day unable to work) _____.

REPORT OF SERVICES (Or attach itemized bill) (If previous form submitted to their carrier, you need show only dates and services since last report)

DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE - IF USED	CHARGES

IO – Doctor's Office IH – Inpatient Hospital NH – Nursing Home H – Patient's Home OH – Outpatient Hospital OL – Other Locations

Exact date patient will be able to return to work at trade:

If exact date is unknown, please estimate:

Is patient still under your care for this condition?	Yes ☐	No ☐

If YES, give date of last treatment:

If YES, give date of next scheduled appointment:

If NO, give date treatment terminated:

Physician's Signature:	Date:
Physician's Name (please print)	Degree:

Address:

City: State: Zip:

Telephone Number:

Fax Number: