

# MICHIGAN LABORERS' HEALTH CARE FUND

6525 Centurion Drive  
Lansing, MI 48917  
Toll Free: (877) 645-2267

## STATEMENT FOR LOSS OF TIME BENEFITS

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

Name:	Date of Birth:
Street Address:	
Member ID or Social Security #:	Local Union #:
Is this claim based on an accident/injury?	Yes      No
Nature of sickness or accident/injury:	
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?	
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:

