Laborers' District Council Trust Funds

LOSS OF TIME FROM WORK DUE TO ACCIDENT OR SICKNESS

FORM L.L.-123

Mail all claims and inquiries to the Fund Office of the

LABORERS' DISTRICT COUNCIL HEALTH & WELFARE
TRUST FUND NO. 2
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
PHONE (410) 872-9500

FUND NO. 22	

Remember: Incomplete Claims Cannot be Processed.

Member's Name: _____

Address: _____

_____

LOCAL:

Members' Social Security Number

☐☐☐ ☐☐ ☐☐☐☐

Employers for the last 12 months:

_____

_____

_____

I certify that I was TOTALLY disabled on _____(date) and did not work at all during this period, that I was not paid by my employer and that I did not apply for or receive unemployment or Workmen's Compensation for this period.

X _____
SIGNATURE OF MEMBER DATE

PHYSICIAN MUST COMPLETE THIS SECTION:

Diagnosis: (please use CPT codes) _____

_____

_____

WAS CONDITION RELATED TO AN ACCIDENT/INJURY:	WAS CONDITION RELATED TO PATIENT'S EMPLOYMENT:
YES ☐☐ NO	YES ☐☐ NO
DATE OF INJURY:	PLACE OF INJURY:

PLACE OF TREATMENT:

DATES OF HOSPITALIZATION:

GENERAL PROVISIONS

If a doctor certifies that an eligible member is disabled and prevented from working as a result of any nonoccupational accident or disease, the Fund pays a weekly benefit per the summary for the duration of the disability up to a maximum of 13 weeks in a calendar year, *as long as he continues to be eligible.*

No benefits are payable if the disease or accident is directly related to member's occupation and may be covered under the Workmen's Compensation Law. If the disability is due to illness, benefits will be paid from the eighth day of disability; if the disability is due to injury, benefits will be paid from the first day.

Disability will be considered as beginning with the first examination and ending with the last examination by a medical doctor.

The member must be under the care of a medial doctor who sees him at least once a week during the period of his disability, even if there is no charge for the visit. It is not necessary to be confined to home to collect benefits.

No additional waiting period will be required for successive periods of disability arising from the same medical condition separated by less than two weeks of continuous active employment.

The Fund may require an examination by the Fund's medical consultant to verify and substantiate a claim.

I Certify that the patient named herein was under my care and was/will be TOTALLY disabled.

from: _____
DATE OF DISABILITY

to: _____
DATE OF RETURN TO WORK

X _____
SIGNATURE OF PHYSICIAN DATE

Physician's Name: _____

Address: _____

_____

_____

_____

Telephone Number: _____

_____

7130 COLUMBIA GATEWAY DRIVE, SUITE A, COLUMBIA, MD 21046

Phone: (410) 872-9500

SUPPLEMENTARY CERTIFICATE OF ATTENDING PHYSICIAN

Note: No further benefits can be paid until this form is completed and returned to the Fund office.

ATTENDING PHYSICIAN'S SUPPLEMENTARY REPORT OF DISABILITY

1. Patient's name

   What is patient's present ailment?

2. What complications have arisen since last report?

3. On what dates, since your last report, did you treat the patient

   a. at his home?

   b. at your office?

   c. in the hospital?

4. Was patient confined to hospital? If so,

   date entered _____ discharged _____

5. Is patient still under your care for this condition?

   ☐ Yes ☐ No

6. Patient was continuously totally disabled (unable to work)

   From _____ thru _____

7. If still disabled, date patient should be able to return to work

   If not certain please indicate approximate date _____

8. Date actually returned to work

   _____

REMARKS: _____

_____

_____

Date	Physician's Name (Print)	Signature	
Degree	Telephone	Street Address	City or Town
Federal I.D. No.		State or Province	Zip Code