EWBTF
Electrical Workers Benefit Trust Fund

T 317.923.4577 | **F** 317.923.7633 | **E** info@ewbtf.org
1828 North Meridian Street – Suite 103, Indianapolis, IN 46202

LOSS OF TIME CLAIM

Participant Information			
Name:	**SSN:**		**Date of Birth:**
Address:			
City:	**State:**		**Zip:**
Cell Phone:	**Email Address:**		
Employer Name:		**Employer Phone Number:**	
Date of Injury or Symptoms:			
Was the illness or injury work related?	Yes		No
What is your general condition at this time and what prevents you from returning to work?			
Attending Physicians Statement – Required for Payment			
Patient's Name:			**Date of Birth:**
Is the patient presently under your care for this condition and unable to work?	Yes		No
Date of first examination:			
Nature of illness or injury causing the insured to be unable to work:			
Date patient had to stop working:		**Date of estimated return:**	
A new loss of time claim form must be completed if the patient is off work longer than anticipated.			
Date patient can return with restrictions:		**Date restrictions lifted:**	
Physician's Name:		**Phone Number:**	
Address:			
City:	**State:**		**Zip:**
Physician's Signature:			**Date:**

All of the information is true to the best of my ability. I agree to notify the EWBTF immediately upon returning to work.

Signature:	**Date:**