MICHIGAN BAC HEALTH CARE FUND

6525 Centurion Drive
Lansing, MI 48917
Toll Free: (800) 531-2244

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:	

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ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's Name:	Member Identification #:	Date of Birth:

Diagnosis and Concurrent Conditions:

ICD9 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:

Erase and type over this text.
Press <ENTER> to start a
new line within this box.

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

through (last day unable to work) _____

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:

Telephone Number: Fax Number: