

MICHIGAN BAC HEALTH CARE FUND

6525 Centurion Drive
Lansing, MI 48917
Tollfree Telephone: 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:	
Address:	City:	State:	Zip:
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:			
Signature:		Date:	

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ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's Name:		Date of Birth:	
Diagnosis and Concurrent Conditions:			
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:			
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:			
City:		State:	Zip:
Telephone Number:		Area Code:	