

**PLUMBING AND PIPEFITTING INDUSTRY  
HEALTH AND WELFARE FUND OF KANSAS**

505 S. BROADWAY, SUITE 117  
WICHITA, KANSAS 67202-3922

PHONE (316) 264-2339  
FAX (316)264-9245

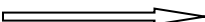
E-MAIL fundoffice@ppi-fund.org

**INITIAL REPORT FOR GROUP LOSS OF TIME BENEFITS**

**THIS SECTION TO BE COMPLETED BY INSURED MEMBER**

MEMBER'S FULL NAME		DATE OF BIRTH		SOCIAL SECURITY #
ADDRESS	CITY	STATE	ZIP CODE	AREA CODE - PHONE #
DATE YOU WERE FIRST UNABLE TO WORK		DATE YOU RETURNED TO WORK (IF APPLICABLE)		

WAS DISABILITY WORK RELATED? YES <input type="checkbox"/> NO <input type="checkbox"/>	HAS THERE BEEN, OR WILL THERE BE, A CLAIM FILED FOR THIS DISABILITY WITH A WORKMAN'S COMPENSATION CARRIER? YES <input type="checkbox"/> NO <input type="checkbox"/>
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<b>IF YOU WERE INJURED</b> 	DATE ACCIDENT OCCURRED?	TIME ACCIDENT OCCURRED?
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WERE YOU AT WORK WHEN ACCIDENT OCCURRED? YES <input type="checkbox"/> NO <input type="checkbox"/>	DESCRIBE THE ACCIDENT
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DESCRIBE THE DISABILITY

NAME & ADDRESS OF CURRENT EMPLOYER

LOCAL                      UNION                      441

I HEREBY CERTIFY THE STATEMENTS HEREON & ATTACHED ARE COMPLETE & ACCURATE.  
I AUTHORIZE ANY PERSON OR INSTITUTION RENDERING CARE OR ANY PERSON OR ORGANIZATION IN POSSESSION OF INSURANCE OR OTHER BENEFIT INFORMATION CONCERNING ME, TO FURNISH OR DISCLOSE ALL KNOWN FACTS CONCERNING THIS DISABILITY. A COPY OR PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.  
**IF MY CLAIM IS ACCEPTED AS VALID AND IF THE PLAN SHOULD DECIDE IT IS NECESSARY, I AGREE TO A PHYSICAL EXAMINATION BY A PHYSICIAN OF THE ADMINISTRATOR'S CHOOSING, AS A PREREQUISITE TO FURTHER LOSS OF TIME BENEFITS.**

DATE	<b>EMPLOYEE'S SIGNATURE</b>

**OPPOSITE SIDE TO BE COMPLETED BY ATTENDING PHYSICIAN**

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**ATTENDING PHYSICIAN'S STATEMENT**

PATIENT'S NAME					DOB
DIAGNOSIS AND CURRENT CONDITIONS					
DATE & DESCRIPTION OF SURGICAL PROCEDURES					
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DATES OF SERVICES AND OFFICE VISITS					
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT OCCURRED:			DATE PATIENT FIRST CONSULTED YOU FOR THIS:		
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO			IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO		
PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK):					
FROM:			TO:		
IF STILL DISABLED, DATE PATIENT <b>SHOULD</b> BE ABLE TO RETURN TO WORK WITHOUT ANY RESTRICTIONS			WERE YOU THE FIRST PHYSICIAN TO TREAT THE PATIENT FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO		
PHYSICIAN'S NAME (PLEASE PRINT)			PHYSICIAN'S SS# OR EMPLOYER ID#		
ADDRESS		CITY		STATE	ZIP CODE
					AREA CODE-PHONE #
<b>PHYSICIAN'S SIGNATURE</b>			DEGREE		DATE