Westchester Heavy Construction
Laborers Health & Welfare Fund
Local No. 60
140 Broadway
Hawthorne, N.Y. 10532
Tel. 914 - 769-2440

SUPPLEMENTARY REPORT FOR GROUP LOSS OF TIME BENEFITS

TO BE COMPLETED BY THE INSURED MEMBER

1. Member's full name_____ Age____ Sex____ Social Security or Certificate No._____

2. Describe any change in condition_____

3. Have you resumed any duties? Yes ☐ No ☐ Date returned to work_____, 19__ Date expected to return to work_____, 19__

4. Name of group_____ Master Policy No._____

5. Date_____, 19__ Signed_____ (Signature of Member)

6. Your mailing address_____ (Street and Number) (City) (State) (ZIP Code)

TO BE COMPLETED BY MEMBER'S EMPLOYER IF TIME LOSS INVOLVED

1. Date returned to work_____, 19__ Date expected to return to work_____, 19__

2. Do you know of any circumstances which may affect the payment of further benefits for this claim? Yes ☐ No ☐
If yes, explain_____

3. Name of employer_____

4. Date_____, 19__ Signed_____ (Employer's Representative) (Title)

TO BE COMPLETED BY POLICYHOLDER (Please Use Typewriter)

1. Do you know of any circumstances which may affect the payment of further benefits for this claim? Yes ☐ No ☐

If yes, explain_____

2. Name of policyholder_____ Master Policy No._____

3. Date_____, 19__ Signed_____ (Authorized Representative) (Title)

OPPOSITE SIDE IS FOR ATTENDING PHYSICIAN'S REPORT

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

(1) Patient's name _____ Age _____

(2) Nature of sickness or injury (Describe complications, if any) _____

(3) Give dates of treatments:

Charge Per Call

Office _____ $ _____

Home _____ $ _____

Hospital _____ $ _____

(4) The patient has been continuously disabled (unable to work) from _____ 19___ through _____ 19___

If still disabled, when should patient be able to return to work? _____ 19___

(5) Remarks: _____

Date | Physician's Name (Print) | Social Security

Physician's Signature | Degree | Telephone

Street Address | City or Town | State or Province | ZIP Code