# Loss of Time/Disability Medical Update
# For Continuation of Benefits

**In accordance with the Disability Plan Rules, you are required to be seen by your physician and have this form completed to continue loss of time benefits.**

It is the responsibility of the member to see that questions and information requested are completed and the form returned to the plan office at **6900 Wedgwood Road N., Suite 425, Maple Grove, MN 55311, Ph. (763) 493-8830 or (800) 368-9045**

**Please Type or Print**

1. Name ______________________ Social Security Number ______________________
2. Home Address ______________________ Phone Number ______________________
   Date of Birth ______________________

3.a) Diagnosis/Injury ______________________

b) Brief History ______________________

4. Surgical Procedure ______________________

   ______________________

5. Date of most recent visit/treatment: ______________________
6. Frequency of treatments: ______________________

   ______________________

7. Does employee continue to be disabled from performing his/her job? Yes________No________

   Remarks if any: ______________________

   ______________________

8. When will employee be able to return to work? (Please estimate)

   ______________________

Doctor's Signature ______________________ Date Signed ______________________

Doctor's Name ______________________

Address ______________________

**Send Medical Documentation** ______________________

Phone Number ______________________

Doctor's I.D. Number ______________________

*I hereby authorize release of medical information to IBEW Local 292 Health Care Plan to receive Loss of Time benefits and do certify that the above statement is true.*

Date ______________________ Employee's Signature ______________________