GREATER KANSAS CITY LABORERS FRINGE BENEFIT FUNDS

Managed for the Trustees by:
TIC INTERNATIONAL CORPORATION
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APPLICATION FOR LOSS OF TIME/DISABILITY HOURS

Participant's Name_____ Social Security Number _____

Address _____

Name of Employer _____

If disability is the result of an accident, please complete the following:

- Date accident occurred _____
- Were you at work when the accident occurred? ☐ YES ☐ NO
- Describe the accident (how, when and where occurred)_____

_____

- Have you returned to work? ☐ YES ☐ NO If YES, when _____
- If NO, when do you expect to be able to return to work?_____

Participant's Signature_____ Date signed_____

ATTENDING PHYSICIAN OR SURGEON'S STATEMENT

Patient's Name _____

Nature of sickness or injury _____

_____

Date of first treatment_____

Frequency of treatments _____

Patient has been continuously disabled (unable to work): From_____ To_____

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

Physician's Signature_____ Date signed _____

Address _____

Degree_____ Phone Number _____