OREGON PROCESSORS EMPLOYEES TRUST

P.O. Box 4247
Portland, OR 97208

Salem: (503) 364-5942
Inside Oregon: 1-800-452-3667
Outside Oregon: 1-800-533-3001

# STATEMENT OF CLAIM FOR TIME LOSS BENEFITS

**REGULAR EMPLOYEE**

| EMPLOYEE NAME | | EMPLOYER NAME | |
|---|---|---|---|
| Employee Address | | City, State, Zip Code | |
| Social Security Number | Birhtdate (MM/DD/YY) | Date Resumed Work | Date Expected to Resume Work |
| Is this disability the result of occupational disease or injury arising in the course of employment? ☐ Yes ☐ No | | Is this disability the result of a non-occupational accident? ☐ No ☐ Yes | |
| If Yes, How | | When | Where |

## EMPLOYER'S REPORT

| First Full Day Unable To Work | Date Expected to Resume Work | Date Resumed Work |
|---|---|---|
| Do you have any information indicating that the above employee is no longer disabled? ☐ No ☐ Yes | If Yes, Please Explain | |
| | | |
| Date Completed | Employer Name | |
| Telephone Number | Completed By | |

## ATTENDING PHYSICIAN'S STATEMENT

(To Be Furnished Without Expense To The Insurance Company)

**(GROUP INSURANCE)**

| 1. Patient Name | | 2A. Nature of Sickness / Injury (Describe Complications, if Any) | |
|---|---|---|---|
| | | 2B. Is Condition due to injury or sickenss arising out of patient's employment? ☐ No ☐ Yes | |
| 3A. Date of First Treatment | 3B. Date of Most Recent Treatment | 3C. Frequency of Treatments | |
| 4. The patient has been continuously Disabled (unable to work) From | Thru | If still Disabled, When Should Patient Be Able to Return to Work? | If Exact Date Unknown, Please Estimate |
| 5. Remarks | | | |
| | | | |
| | | | |
| | | | |
| Date Signed | Attending Physician Signature | | Degree |
| | Address | | |