DISTRICT COUNCIL NO. 3
PAINTERS AND ALLIED TRADES TRUST FUND

PO Box 909500
Kansas City, MO 64190-9500
(816) 756-3313
Toll Free: 1-866-756-3313

LMCI MATERNITY LEAVE BENEFITS FORM

Member and Physician must complete this form in full.

CLAIMANT'S STATEMENT (MEMBER)

Name _____ SS# _____

Address _____

Expected Due Date? _____

Last date worked: _____ When do you expect to return to work? _____

Date_____ Signed: _____

ATTENDING PHYSICIAN OR SURGEON'S STATEMENT

Patient's Name: _____

Patient is continuously unable to work: Expected Due Date:

From (date): _____ (date) _____

Through (date): _____

Approximately when should patient be able to return to work? _____

Date: _____ Signed: _____

Name (printed): _____

Address: _____

Phone: _____