LOCAL UNION 373 UA HEALTH & WELFARE FUND
STATEMENT OF CONTINUANCE OF DISABILITY

CLAIM No._____

INSTRUCTIONS: This form must be submitted by the individual claimant to the Fund office and fully completed by the participant and his/her physician. In addition, as this is a supplement to Statutory Disability or Worker's Compensation, this form must be accompanied by the Explanation of Benefits from the statutory insurance carrier.

TO BE COMPLETED BY INSURED PARTICIPANT

1. WHAT IS YOUR FULL NAME?_____

2. WHAT IS YOUR HOME ADDRESS?_____
STREET CITY/ZIP CODE STATE

3. ARE YOU STILL TOTALLY DISABLED BY THE SICKNESS OR INJURY?_____

4. ARE YOU NOW WHOLLY UNABLE TO PHYSICALLY ENGAGE IN ANY WORK, OCCUPATION OR _____

5. ON WHAT DATE WERE YOU LAST TREATED BY A PHYSICIAN?_____

6. HAVE YOU RETURNED TO WORK?_____IF SO, ON WHAT DATE?_____

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME.

DATE:_____ SIGNATURE OF INSURED PARTICIPANT:_____

PLEASE RETURN THIS FORM AND EXPLANATION OF BENEFITS FROM STATUTORY CARRIER TO:

LOCAL UNION 373 BENEFIT FUNDS
PO BOX 58/76 PLEASANT HILL ROAD
MOUNTAINVILLE, NY 10953

(OVER)

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

1. Patient's Name_____ Age_____

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

_____

_____

3. (a) Date of first treatment_____ 20_____

(b) Date of most recent treatment_____ 20_____

c) Frequency of treatments_____

4. The patient has been continuously disabled (unable to work) from _____ 20_____ through_____ 20_____

If still disabled, when should patient be able to return to work?_____ 20_____

5. Remarks:_____

_____

_____

_____

Date_____, 20_____

Signed_____, MD
(Attending Physician)

Federal Tax ID:_____
(Must be furnished under authority of law.)

Address_____

_____

_____

Phone_____

(GDS-1)
REVISED 3/05/2018