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 participat 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 Explination 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 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 EXPLICATION OF BENEFITS FROM STATUTORY CARRIER TO:

LOCAL UNION 373 BENEFITS FUNDS
PO BOX 58 - 76 PLEASANT HILL ROAD
MOUNTAINVILLE, NY 10953

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ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

1. Patients Name: _____ Age: _____

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

_____

_____

3 (a) Date of first treatment: _____

(b) Date of most recent treatment: _____

(c) Frequency of treatments: _____

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

through: _____

5. Remarks: _____

_____

_____

_____

Date: _____ Signed: _____, MD

(Attending Physician)

Federal Tax ID: _____ Address: _____

(Must be furnished under authority of law.)

_____

_____

Phone: _____

(GDS-1)

Form Updated 01/28/25