

# IBEW-NECA SOUTHWESTERN HEALTH AND BENEFIT FUND

## GROUP HEALTH INSURANCE CLAIM FORM

### STATEMENT OF CONTINUANCE OF DISABILITY

Forward Completed Form To:

IBEW-NECA Southwestern Health & Benefit Fund

P.O. Box 819015

Dallas, Texas 75381-9015

(972) 980-1123 - (800) 527-0320 - Fax (972) 341-8097

#### TO BE COMPLETED BY EMPLOYEE:

(1) Patient's Name \_\_\_\_\_ S.S. No. \_\_\_\_\_ Age \_\_\_\_\_

Member's Address & Local # \_\_\_\_\_

Last Day Worked \_\_\_\_\_

(2) Nature of sickness or injury (Describe complications, if any) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

#### TO BE COMPLETED BY ATTENDING PHYSICIAN:

(3) Is this patient's ailment due to injury or illness arising out of or in the course of employment? Yes  No

(4) Is ailment due to an accident? Yes  No

If yes, when \_\_\_\_\_, 20\_\_\_\_\_,  a.m.  p.m.

Where \_\_\_\_\_

How \_\_\_\_\_

(5) (a) Date of first treatment \_\_\_\_\_, 20\_\_\_\_

(b) Date of most recent treatment \_\_\_\_\_, 20\_\_\_\_

(c) Frequency of treatments \_\_\_\_\_

(6) 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\_\_\_\_

Please provide approximate dates or time periods. We cannot accept "undetermined."

(7) Remarks \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Physician's Name \_\_\_\_\_  
(Please Print)

Signature \_\_\_\_\_ Degree M.D.  
(Attending Physician)

Address \_\_\_\_\_

Date \_\_\_\_\_ 20\_\_\_\_ Phone \_\_\_\_\_

Please notify the Fund Office the date you return to work

