

CENTRAL STATES SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE FUND

LOCAL UNION _____

RETURN THIS FORM TO _____

CLAIMANT'S REPORT OF CONTINUED DISABILITY
 CENTRAL STATES SOUTHEAST & SOUTHWEST AREAS
 HEALTH & WELFARE FUND
 CLAIMS PROCESSING - A & H
 P.O. BOX 5107 DES PLAINES, IL 60017-5107

CLAIM NO. _____
SOCIAL SECURITY NO. _____

INSTRUCTIONS TO CLAIMANT:

1. EVERY ITEM MUST BE COMPLETED IN FULL BY YOURSELF, YOUR DOCTOR AND YOUR EMPLOYER.
2. CLAIMS CANNOT BE CONSIDERED UNLESS THESE INSTRUCTIONS ARE STRICTLY COMPLIED WITH.

1. Covered Member's full name _____ Soc. Sec. Number _____
 Local Union No. _____
 2. Covered Member's full street address _____
 City and State _____ Zip Code _____ Employer _____

THIS IS TO CERTIFY THAT I HAVE NOT YET RETURNED TO WORK OR RETIRED.

DATE _____ SIGNED _____

PHYSICIAN'S SUPPLEMENTARY STATEMENT

1. Patient's name _____

2. Have any complications or other conditions arisen since last report? _____
 If so, please explain nature and effect _____

3. Dates you attended patient: At home and hospital _____ At your office _____

4. If patient hospitalized since last report, state name _____ From _____ To _____

5. What operation was performed? _____ Date _____

6. Is patient's condition such as to prevent performance of any and every duty of employment? Yes No

7. On what date will patient first be able to resume normal occupational duties? _____

Dated _____ (Signed) _____ (Attending Physician)
 Street _____ City _____ State _____ Phone _____

EMPLOYER'S STATEMENT

What was Claimant's last day worked? _____

Is Claimant still off work because of Disability? Yes No

If Claimant is working, when did he resume work? _____

Signed _____

Dated _____

LOCAL UNION STATEMENT

A. The above claim does not come under Workman's Compensation Act

B. The above claimant is a member of our local

Date _____ Local _____

 Signature of Representative of Local Union