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