Return this form to:

4TH DISTRICT IBEW HEALTH FUND
3150 RT. 60
ONA, WV 25535

STATEMENT OF CONTINUANCE OF DISABILITY

INSTRUCTIONS: This form must be submitted by the individual claimant to the Administrative Office properly and fully completed and signed by himself, and his physician.

TO BE COMPLETED BY COVERED EMPLOYEE

What is your full name?____________________ Social Security No.____________________

What is your home address?____________________

Are you still totally disabled by this sickness or injury?____________________

Are you now wholly unable to physically engage in any work, occupation or business?____________________

On what date were you last treated by a physician?____________________

Have you returned to work?____________________ If so, on what date?____________________

DATE:____________________ SIGNATURE OF EMPLOYEE:____________________

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's name____________________

Nature of sickness or injury (describe complications, if any)____________________

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Date of first treatment____________________

Date of most recent treatment____________________

Frequency of treatments____________________

The patient has been continuously disabled (unable to work) from ____________________ through____________________

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

REMARKS:____________________

____

Date____________________ Signed____________________ M. D. (degree)

Address____________________

____

Phone____________________

GCC/IBT