

IBEW-NECA SOUTHWESTERN HEALTH AND BENEFIT FUND

GROUP HEALTH INSURANCE CLAIM FORM

Forward Completed Form To:

STATEMENT OF CONTINUANCE OF DISABILITY

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

