

TEAMSTERS HEALTH AND WELFARE FUND
of Philadelphia and Vicinity

REPORT OF CONTINUED DISABILITY

Forms due on Wednesday at 12:00 noon

This report must be filled out and returned
before any additional payments can be made to you.

I. CLAIMANT'S STATEMENT

1. Name _____ Social Security Number _____
2. Are you still unable to work because of total disability? _____ Yes _____ No
3. If not now disabled, on what date did you return to work? _____
4. If not now working, when will you probably do so? _____
5. Have you been attended by a physician since the date of last report? _____ Yes _____ No. If yes, give dates of attendance by physicians:
 - a. At hospital _____
 - b. At physician's office _____
 - c. At home _____
6. Has there been any hospitalizations not covered in previous report? _____ If yes, give name and address of hospital _____
 - a. Date admitted _____
 - b. Date discharged _____
7. Have you received, since the commencement of your disability, any payments from your employer for vacation, sick leave or any other form of paid leave? _____ Yes _____ No If yes, list dates and amounts received.

8. Are/have you applied for Pension Benefits? _____ Yes _____ No If yes, Pension effective date _____
Date _____ Signature _____

II. ATTENDING PHYSICIAN'S STATEMENT

1. Name of patient _____
 2. Are there any new complications since date of last report? _____ If yes, give details

 3. Is the patient now physically unable to work because of injury or sickness? _____ Yes _____ No
 4. When, in your opinion, will he (she) be able to work? _____
 5. Is the patient able to do light duty work if available? _____ Yes _____ No
If yes, give details _____
 6. Please give the dates of all calls since last report:
 - a. At hospital _____
 - b. At your office _____
 - c. Elsewhere (home, etc.) _____
- Date _____ Signature _____
Address _____ Phone Number _____

(over)

III. EMPLOYER'S STATEMENT

1. Name of **employee** _____
2. If employee is back to work, give date of return _____
3. If employee is able to do light duty work, is it available? _____ Yes _____ No If yes, provide date light duty work is available _____
4. If employee is not back to work, when do you expect him back _____
5. Since the employee's last day of work, have any payments been made to the employee for vacation, sick leave or any other form of paid leave? _____ Yes _____ No If yes, list dates, type of paid leave and amounts.

Date _____

Company Name: _____

Address: _____

Phone Number: _____

Signed By: _____