

TEAMSTERS HEALTH AND WELFARE FUND
of Philadelphia and Vicinity

REPORT OF CONTINUED DISABILITY

Forms due on **Tuesday by 5:00 pm**
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 physician:
- a. At hospital: _____
- b. At physician's office: _____
- c. At home: _____
6. Has there been any hospitalizations not covered in previous report? _____ Yes _____ No
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 amount 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: _____

Address: _____

Phone Number: _____

Signed By: _____