Union LaborLife

The Union Labor Life Insurance Company

STATEMENT OF CONTINUANCE OF DISABILITY

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

TO BE COMPLETED BY INSURED EMPLOYEE

1. WHAT IS YOUR FULL NAME? _____ SOC SEC # _____

2. WHAT IS YOUR HOME ADDRESS? _____

STREET CITY STATE

3. ARE YOU STILL TOTALLY DISABLED BY THIS SICKNESS OR INJURY? _____

4. ARE YOU NOW WHOLLY UNABLE TO PHYSICALLY ENGAGE IN ANY WORK, OCCUPATION OR BUSINESS? _____

5. ON WHAT DATE WERE YOU LAST TREATED BY A PHYSICAN? _____

6. HAVE YOU RETURNED TO WORK? _____ IF SO, ON WHAT DATE? _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

DATE: _____ SIGNATURE OF INSURED EMPLOYEE: _____

TO BE COMPLETED BY POLICYHOLDER

NAME OF POLICYHOLDER

General Building Laborers Local #66 Welfare Fund

ADDRESS OF POLICYHOLDER

1600 Walt Whitman Road, Melville, Long Island, NY 11747

GROUP POLICY NUMBERS	CERTIFICATE NUMBER	
C-2296		
DATE	SIGNATURE OF POLICHOLDER'S REPRESENTATIVE	

CLM-8N

(over)

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

(1) Patient's name _____ Age _____

(2) Nature of sickness or injury (Describe complications, if any) _____

_____

_____

_____

(3) (a) Date of first treatment _____ 20_____

(b) Date of most recent treatment _____ 20_____

(c) Frequency of treatments _____

(4) 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_____

(5) Remarks: _____

_____

_____

_____

Date _____, 20 _____

Signed _____ M.D.
(Attending Physician)

Address _____

_____

Physician's Tax Id. No. _____

(Must be furnished under authority of law.)

Phone _____

(GDS-1)