UFCW Unions
& Participating Employers
HEALTH & WELFARE FUND
P.O. Box 1064
Sparks, MD 21152-1064
1-800-638-2972

LOCAL_____ PLAN_____ FUND_____

NOTICE OF CONTINUATION OR TERMINATION OF DISABILITY FOR GROUP ACCIDENT AND SICKNESS BENEFITS

DATE

THIS FORM MUST BE RETURNED TO THE FUND OFFICE WITHIN 2 WEEKS OR YOUR FILE WILL BE CLOSED.

ALL QUESTIONS MUST BE ANSWERED OR YOUR FORM WILL BE RETURNED.

EMPLOYEE ONLY COMPLETE THIS SECTION

CLAIM FOR BENEFITS

1. Employee's Name _____ Employed By _____
2. SSN _____
3. Have you returned to work? Yes___ No___ If "Yes", give date _____
4. If still disabled, when do you expect to return to work? _____
5. Have you applied for or are you receiving Workers' Compensation benefits? _____ Yes ☐ No ☐
6. Have you received any wages for work you have done during period for which you have received weekly benefits from this company? Yes ☐ No ☐ If yes, please indicate period of time worked and amount of wages received.

   _____
7. Have you received Unemployment Insurance Benefits during any period for which you have claimed Disability Benefits?

   Yes ☐ No ☐

I hereby certify that the foregoing statements, including any accompanying statements, are true, correct and complete to the best of my knowledge and hereby further autorize my attending physician, practitioner or hospital in which confinement took place to furnish and disclose all facts concerning my physical condition that are within their knowledge.

Date _____ Signature _____

Mailing Address _____

(PHYSICIAN ONLY MUST SIGN AND COMPLETE)

ATTENDING PHYSICIAN'S STATEMENT

1. Patient's Name _____ Age _____
2. Nature of sickness or injury (Describe complications, if any since last report) _____

   _____
3. Nature of Surgical Procedure if any (describe fully) _____

   _____
4. Give dates of treatments since last report:

   Office _____ Home or Telephone Consultation _____ (Specify)

   Hospital _____ (Specify inpatient, out patient or emergency room)
5. 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 ____
   (If unknown, project a date.)

Date _____ 20 _____ Signed_____ M.D.

Phone _____ Print Name _____

Address _____

_____

EMPLOYER ONLY COMPLETE THIS SECTION

Has employee returned to work since originally disabled? Yes ☐ No ☐
If yes, on what date? _____ If no, estimated date of return _____

Do you have any information indicating that the above employee is no longer disabled? Yes ☐ No ☐
If yes, explain _____

Has vacation, personal holiday or holiday been paid during disability? Yes ☐ No ☐ If yes, please list dates paid

_____

Is accident or illness due to employment? Yes ☐ No ☐

Signature of Authorized Employer _____

Telephone Number ( )_____ Date _____

02/06