LAKE COUNTY INDIANA N.E.C.A. – I.B.E.W.
HEALTH & BENEFITS PLAN

STATEMENT OF CONTINUANCE OF DISABILITY

THIS PART TO BE COMPLETED BY THE MEMBER:

1. **FULL NAME:_____BIRTHDATE:_____**
2. **HOME ADDRESS:_____**
3. **ARE YOU STILL TOTALLY DISABLED BY THIS SICKNESS AND OR INJURY?**

   YES_____NO_____
4. **ARE YOU NOW WHOLLY UNABLE TO PHYSICALLY ENGAGE IN ANY TYPE OF WORK?**

   YES_____NO_____
5. **ON WHAT DATE WERE YOU LAST TREATED BY A PHYSICIAN?_____**
6. **HAVE YOU RETURNED TO WORK? YES_____NO_____, IF SO, ON WHAT DATE?**

   _____

SIGNATURE OF MEMBER_____DATE_____

THIS PART TO BE FILLED OUT BY THE ATTENDING PHYSICIAN:

1. **PATIENT'S**

   NAME:_____BIRTHDATE:_____
2. **NATURE OF SICKNESS/INJURY (DESCRIBE COMPLICATIONS, IF**

   ANY):_____

   _____

   _____
3. **DATE OF FIRST TREATMENT:_____**
4. **DATE OF MOST RECENT TREATMENT:_____**
5. **FREQUENCY OF TREATMENTS:_____**
6. **THE PATIENT HAS BEEN CONTINUOUSLY DISABLED FROM**

   DATE_____THRU_____
7. **IF STILL DISABLED, WHEN SHOULD PATIENT BE ABLE TO RETURN TO WORK?**

   _____
8. **REMARKS:_____**

   _____

SIGNATURE OF ATTENDING PHYSICIAN:_____DATE:_____

PHYSICIAN

ADDRESS:_____

PHYSICIAN PHONE:_____

MAIL COMPLETED FORM TO: 7200 MISSISSIPPI STREET, SUITE 300, MERRILLVILLE, IN 46410