CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND

P.O. Box 15224, Reading, PA 19612-5224 Phone: (610) 320-5500

*** THIS FORM MUST BE RETURNED WITHIN 2 WEEKS TO AVOID DELAY IN FUTURE DISABILITY PAYMENTS. ***

REPORT OF CONTINUED DISABILITY

I. CLAIMANT'S STATEMENT

1. Your Name_____
2. Identification No._____
3. Are you still unable to work because of total disability?_____
4. If not now disabled, when did you return to work?_____
   Month Day Year
5. If not now working, when will you probably do so?_____
   Month Day Year
6. Have you been attended by a physician since date of last report?_____
   If so, give dates of attendance by physician:
   a. At Hospital_____
   b. At Physician's Office_____
   c. At Home_____

Date_____ Signature_____

II. ATTENDING PHYSICIAN'S STATEMENT

1. Name of Patient_____
2. Are there any new complications since date of last report?_____
   If so, give details_____
3. Is the patient now physically unable to work because of injury or sickness?_____
4. When, in your opinion, will he be able to work?_____
   Month Day Year
5. Please give the dates of all calls since last report:_____
   a. At Hospital_____
   b. At your Office_____
   c. Elsewhere (home, etc.)_____
6. Has any surgery been performed since date of last report?_____
   If so, give the following information:
   a. Date of Surgery_____ b. Where Performed_____
   b. Nature of Surgery_____
7. Has there been any hospitalization not covered in previous report?_____
   If so, give name and address of hospital:_____
   a. Date Admitted_____ b. Date Discharged_____

Date_____ Signature_____

Address_____