United Food and Commercial Workers Union Local 1529

and Employers Health and Welfare Plan and Trust

1. Complete this form
2. Mail to →

661 N Ericson Road
Cordova, TN 38018-5806

Telephone 901-758-3000
1-800-874-8499
Fax 901-758-3021

Statement of Continuance of Disability

Instructions: Form must be completed. Incomplete forms will be returned.

To be Completed by Insured Employee

Last Name:_____First Name:_____MI:___

Social Security Number:_____ Date of Birth:_____

Home Address:_____City:_____State:_____Zip:_____

1. Are you still totally disabled by this sickness or injury?_____
2. Are you still unable to physically engage in any work occupation or business?_____
3. On what date were you last treated by a physician?_____
4. Have you returned to work?_____If so on what date?_____

Date:_____ Signature:_____

Authorization To Release Information. I hereby certify that the above statements are true, correct and complete to the best of my knowledge and belief and I authorize any hospital, physician, or insurance company to disclose any knowledge or information concerning this or other disabilities. A photocopy of this authorization shall be valid as the original.

Signed ▶

X **Date**

To be Completed by Attending Physician

1. Patient's Name:_____Age:_____
2. Nature of sickness or injury (Describe complication, if any)_____

_____

_____

3. (a) Date of first treatment:_____
   (b) Date of most recent treatment:_____
   (c) Frequency of treatment:_____
4. The patient has been continuously disabled (unable to work) from (date)_____to_____
   If still disabled, when should patient be able to return to work? (date)_____
5. Remarks:_____

_____

_____

Signature of Attending Physician:_____Date:_____

Tax ID:_____Phone:_____

Address:_____City:_____State:_____Zip:_____