STATUS REPORT FOR CONTINUING WEEKLY TIME LOSS BENEFITS

ATTENDING PHYSICIAN'S SUPPLEMENTARY REPORT

name of employee

group policy number

name and address of employer

claim number

WE NEED THIS REPORT IN ORDER TO FURTHER CONSIDER YOUR CLAIM FOR PAYMENT

TO BE COMPLETED BY EMPLOYEE

☐ RESUMED WORK
☐ EXPECTED TO RESUME WORK

date

employee's signature

date signed

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. NATURE OF SICKNESS OR INJURY (describe complications, if any):

2. GIVE DATES OF TREATMENT: _____ (date of first treatment) _____ (date of most recent treatment) _____ (frequency of treatments)

3. THE PATIENT HAS BEEN CONTINUOUSLY DISABLED (unable to work) FROM _____ THROUGH _____

IF STILL DISABLED, WHEN SHOULD PATIENT BE ABLE TO RETURN TO WORK? _____

4. REMARKS: _____

please print or type attending physician's name degree

address

city-state-zip code phone

attending physician's signature date

RETURN COMPLETED FORM TO:

ELECTRICAL WORKERS HEALTH AND WELFARE FUND
2002 LONDON ROAD, STE 300, DULUTH, MN 55812
PHONE: (218) 724-8883 TOLL FREE: (877) 908-3863 FAX: (218) 728-4773