

TOLEDO ELECTRICAL WELFARE FUND

COVID-19 INCREASED RISK CERTIFICATION

As evidence by my signature below, I hereby swear and affirm that I presently suffer from one or more of the following medical conditions that the U.S. Center for Disease Control and Prevention (CDC) indicates places me at increased risk of serious illness from COVID-19.

(Please check all that apply)

- Cancer
- Chronic Kidney Disease
- COPD (Chronic Obstructive Pulmonary Disease)
- Heart Conditions (Congestive Heart Failure, Coronary Artery Disease, Cardiomyopathies)
- Immune System Weakness (Due to: _____)
- Obesity (Body mass index of 30 kg/m² or higher)
- Sickle Cell Disease
- Smoking
- Type 2 Diabetes
- Other (Describe: _____)

Signature

Last 4 numbers of SSN

Print Name

Date

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