Toledo Electrical Welfare Fund
Continuation of Short-Term Disability Benefits

419.666.4450 phone 419.666.5410 fax disability@electricalfunds.org email

Disability income payments have been paid to you through: _____

This form must be completed every 4 to 6 weeks by your physician to continue disability payments. This short-term disability benefit is a MAXIMUM of 26 weeks.

SECTION TO BE COMPLETED BY YOUR PHYSICIAN

Patient Name: _____

Nature of Disability: _____

_____

_____

Date of first treatment:_____Date of most recent treatment: _____

Please indicate the ***anticipated*** date the disability will end (est. RTW date): _____

After the above date, will the patient be medically able to return to work? Yes or No (Please circle choice)

If yes, a separate return to work slip is required. **If no**, please indicate date of next evaluation: _____

Physician Name: _____

Telephone: _____ Fax: _____

Physician Address: _____

Physician Signature:_____Date of Signature: _____

PARTICIPANT INFORMATION

Participant Name:_____ Unique ID or SSN: _____

Address: _____

Telephone:_____Date of Birth: _____

RETURN TO ONE OF THE FOLLOWING:

Mail: Toledo Electrical Welfare Fund, P.O. Box 60408, Rossford, OH 43460

Email: disability@electricalfunds.org

Fax: 419-666-5410