North Atlantic States
CARPENTERS BENEFIT FUNDS
Health
Benefits Fund

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Extension of Coverage for Disabled Members

ATTENDING PHYSICIAN'S STATEMENT

Patient Information

Member Name: _____ Date of Birth: _____

Member Address: _____

Member Phone Number: _____ Email: _____

Patient last four SSN or UBC#: _____

Patient Information Related to Diagnosis, Treatment, and History

Please use date format: mm/dd/yy

Date you first consulted patient: _____

Primary diagnosis: _____

Date patient's symptoms first appeared, or accident/injury happened: _____

Is the patient's condition the result of a work-related accident or illness? ○ Yes ○ No

Date patient ceased work from condition: _____

Date patient became totally disabled/unable to perform work duties: _____

Date of next evaluation: _____

Estimated return to work date: _____

Description of injury or illness:

Treating Physician Information

Physician Name: _____

Specialty/Board Certification: _____

Physician Address: _____

Phone Number: _____ Fax Number: _____

Physician's Signature: _____ **Date:** _____

RULES FOR EXTENSION OF COVERAGE FOR DISABLED MEMBERS

The Fund may grant up to a maximum of two free insured periods of coverage for members who are totally disabled and unable to work, provided the member was covered at the time of the illness or injury, and subject to the following rules:

- Member must be covered under plans 1 or 2 at the time of the injury or disability.
- Coverage will be granted only to equal the level of coverage the member already had when injured.
- This benefit will be granted up to a maximum of two (2) insured periods throughout your career.

_____ _____

Patient Signature: **Date:**