North Atlantic States
CARPENTERS BENEFIT FUNDS

Health
Benefits Fund

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Extension of Coverage for Maternity 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:**