United Food and Commercial Workers
Unions and Employers Midwest Health Benefits Fund

Administered by Wilson-McShane Corporation

1431 Opus Place, Suite 350
Downers Grove, IL 60515

DISABILITY CONTINUATION FORM

This form MUST be completed on or about: _____

PART A: *TO BE COMPLETED BY MEMBER (INSURED)*

1. Personal Information

Your Name: _____

Social Security Number: _____

Date of Birth:_____

Address:_____

_____

2. State last day worked because of disability:

_____ / _____ / _____
month day year

3. On what date were or will you be able to perform full-time work:

_____ / _____ / _____
month day year

4. If injured, how and where did the accident occur?

5. Did injury occur in the course of employment? ❑ Yes ❑ No

6. Have you or do you intend to file this claim under Workers' Compensation?

❑ Yes ❑ No

7. Are you now engaged in the duties of any occupation or endeavor for wages, profits or compensation?

❑ Yes ❑ No

9.

_____
MEMBER PHONE # NAME OF EMPLOYER DATE LAST EMPLOYED

I CERTIFY THAT THE ABOVE INFORAMTION IS TRUE AND CORRECT. I HERBY AUTHORIZE ALL DOCTORS, HOSPITALS OR OTHER INSTITUTIONS RENDERING CARE AND TREATMENT TO FURNISH THE UFCW UNIONS AND EMPLOYERS MIDWEST HEALTH BENEFITS FUND WITH FULL INFORMATION REGARDING TREATMENT RENDERED, INCLUDING COPIES OF THEIR RECORDS. I ALSO AUTHORIZE ANY UNION TRUST FUND, EMPLOYER OR INSURANCE CARRIER TO FURNISH THE UFCW UNIONS AND EMPLOYERS MIDWEST HEALTH BENEFITS FUND WITH INFORMATION REGUARDING BENEFITS TO WHICH I OR ANY OF MY DEPENDENTS MAY BE ENTITLED TO.

_____ _____
DATE MEMBER'S SIGNATURE

PART B: *To be completed by Attending Physician:*

1. Diagnosis and concurrent conditions:

2. Frequency of visits:

❑ Weekly ❑ Monthly ❑ Other:_____

3. Is patient totally disabled from any occupation?

❑ Yes ❑ No

Date patient became totally disabled: _____ /_____ /_____
month day year

4. Is patient totally disabled from his/her regular occupation?

❑ Yes ❑ No

Date patient became totally disabled: _____ /_____ /_____
month day year

5. On what date will the patient be able to resume normal activities and return to work?

_____ / _____ / _____
month day year

6. Attending Physician's Information:

Physician's Name: _____

Physician's Signature:_____

Degree:_____ Date:_____

Address:_____

_____

7. Remarks:

_____

_____

_____

_____

_____

11. DOES PATIENT HAVE OTHER HEALTH COVERAGE?

☐ YES ☐ NO IF YES, PLEASE IDENTIFY

Return Completed Forms To:
UFCW Benefits Fund Office
c/o Wilson-McShane Corporation
1431 Opus Place, Suite 350
Downers Grove, IL 60515