

Alaska Electrical Health & Welfare Fund

2600 Denali Street, Suite 200

Anchorage, AK 99503-2782

(907) 276-1246 • (800) 478-1246 • FAX (907) 278-7576

SUPPLEMENTARY DISABILITY CLAIM FORM

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INSTRUCTIONS TO CLAIMANT:

1. Complete this supplementary form each week during your period of disability.
2. Every fourth week, have the attending physician complete the statement below.
3. Return the completed form to the Alaska Electrical Trust Funds.

Name Social Security Number

Mailing Address City State Zip Code

Are you still unable to work? Yes No

If no, give date you returned to work: _____ If yes, when do you expect to return: _____

Employee Signature _____ Date: _____

STATEMENT OF ATTENDING PHYSICIAN:

Patient's Name: _____

Diagnosis: _____

Date of first: _____ Date of most recent visit: _____

Frequency of treatment: _____

Patient has been continuously unable to work through: _____

If still disabled, when should patient be able to return to work? _____

Physician's name (Print) Telephone

Street Address City State Zip Code

Physician's Signature Date

TO BE COMPLETED BY OFFICE CERTIFYING COVERAGE:

For administrative office use only.

Certified by: _____ Date: _____