ALASKA ELECTRICAL HEALTH & WELFARE FUND

Supplementary Disability Claim Form

Return form to:
Alaska Electrical H&W Fund
701 E. Tudor, Suite 200
Anchorage, AK 99503
(907) 276-1246 or (800) 478-1246
Fax (907) 278-7576

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: Complete this supplementary form each week during your period of disability. Every four weeks, have the attending physician complete the statement below. Return the completed form to the address shown above.

_____ _____
Name Last 4 digits of SSN

_____ _____ _____ _____-_____
Street 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 to work?_____

_____ _____
Signature Date

STATEMENT OF ATTENDING PHYSICIAN

Patient's Name:_____

Diagnosis:_____

Date of first visit:_____ 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 (please print):_____ Phone number:_____

Physician's signature:_____ Date:_____

Address of physician:_____ _____ _____ _____-_____
Street City State Zip Code

For administrative office use only:

Certified by:_____ Date:_____

09/16