ALASKA ELECTRICAL HEALTH & WELFARE PLAN
701 E. Tudor, Suite 200
Anchorage, AK 99503
(907) 276-1246
Toll Free: (800) 478-1246

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: 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.

Full Name _____ Last 4 digits of SSN _____

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 to work? _____ / _____ / _____

Signature _____ Date _____

STATEMENT OF ATTENDING PHYSICIAN

Physician's name _____ Phone number _____

Physician's Address _____ City _____ State _____ Zip Code _____

Patient's Full 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 Signature _____ Date _____

For administrative office use only:

Certified By _____ Date _____