

Teamsters Joint Council No. 83 of Virginia Health & Welfare and Pension Funds



Administered by West End Administrators, Inc.
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For Fund Office Use Only

Inc. _____ Date: _____
Pd from _____ through _____
By: _____ Claim # _____
Follow up sent **YES** **NO**

Disability Continuance Form

Please note: No further disability will be paid until this form is completed and returned to the Fund Office.

PART 1. ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT (MUST BE COMPLETED IN FULL)

1. Patient's full name _____
2. Nature of sickness or injury _____
3. Is this work related? **Yes** **No**
4. a. Date of first treatment _____
b. Date of most recent treatment _____
5. The patient has been continuously disabled (unable to work) from _____ and should be able to return to work on _____ (Please give an approximate date if possible).
6. Physician's Name (please print) _____ Phone No. _____
Physician's Signature: _____ Date _____

PART 2. EMPLOYER'S STATEMENT (MUST BE COMPLETED IN FULL)

Employee's Full Name _____ SSN or UID: _____
Name of Company _____ Phone No. _____
Date Returned to Work _____
Employer's Signature _____ Position _____ Date _____