SAN FRANCISCO ELECTRICAL WORKERS HEALTH AND WELFARE TRUST FUND
720 Market Street, Suite 700, San Francisco, CA 94102
Phone (415) 263-3670 ♦ Fax (415) 263-3672

LONG TERM DISABILITY

APPLICATION FOR MAXIMUM OF 6 MONTHS EXTENSION ATTENDING PHYSICIAN'S STATEMENT

TO BE FURNISHED WITHOUT EXPENSE TO THE TRUST

PATIENT'S NAME: SOCIAL SECURITY NUMBER:

DOCTOR - PLEASE NOTE:
THIS DISABILITY PLAN'S CRITERIA FOR DISABILITY DIFFERS AND IS INDEPENDENT FROM CRITERIA USED BY WORKER'S COMPENSATION CARRIERS. ***PLEASE EVALUATE PATIENT ACCORDING TO JOB DESCRIPTION LISTED BELOW. THERE IS NO LIGHT DUTY OR MODIFIED WORK FOR ELECTRICIANS.***

Date patient may return to work (approximately) Date _____

Patient disabled indefinitely? YES ☐ NO ☐

Patient totally disabled? (See description below) YES ☐ NO ☐

DIAGNOSIS - PHYSICIAN'S REMARKS

Is Patient still under your care for this condition? If discharged, give date.

YES ☐ NO ☐ Date _____

AFTER 12 MONTHS OF PAID DISABILITY BENEFITS TO A MAXIMUM OF 18 MONTHS OF BENEFITS

The following definition of Disability should be used as a criteria for medical evaluation and analysis of a claimant's disability for the 13th Month and thereafter:

"For the 13th month and thereafter of Disability Benefits during the same period of disability a claimant will be considered disabled if he is unable to engage in any gainful activity due to a medically determinable physical or mental impairment. The impairment must be so severe as to prevent the individual from engaging **in any kind of gainful work**." **NO LIGHT DUTY OR MODIFIED WORK FOR ELECTRICIANS.**

_____ _____
Date Physician's Signature

_____ _____ _____
Street Address City or Town Phone Number