



Carpenters Southwest Administrative Corporation

ADMINISTRATIVE OFFICE: 533 S Fremont Ave. • Los Angeles, CA 90071-1706 • Tel: (213) 386-8590 • Toll Free (800) 293-1370

www.carpenterssw.org

DISABILITY CONTINUATION FORM

****This form is required on a monthly basis to continue disability benefits****

Part I - Member Statement (Please Print)

In order to further consider your claim for disability benefits, it is necessary for you to submit the information indicated below at least once per month. To avoid delays, please be sure to submit this form no later than 30 days from the date of the previously submitted form.

Member Name _____ Social Security Number _____

Address _____

Please be sure to complete all questions:

1. Has your physician released you to return to work? _____ Yes, I was released on _____
 _____ No
2. Have you returned to work? _____ Yes, I returned on _____
 _____ No
3. Are you receiving:
- | | | |
|-------------------------------|-----------|----------|
| A. Unemployment Compensation? | _____ Yes | _____ No |
| B. Social Security Benefits? | _____ Yes | _____ No |
| C. Worker's Compensation? | _____ Yes | _____ No |
| D. State Disability Benefits | _____ Yes | _____ No |
| E. Carpenters Pension Benefit | _____ Yes | _____ No |
- Effective Date of Pension: _____

4. If still disabled, please give the date of your possible release to return to work: _____

I hereby certify that the statements hereon and attached are, to the best of my knowledge, accurate and I hereby authorize all doctors, Hospitals or other institutions rendering care and treatment to furnish the Southwest Carpenters Health & Welfare Trust with full information regarding this claim, (including copies of records).

Signature of Member _____ Date _____

Part II - Physician Statement (Please Print)

1. _____ has been wholly and continuously disabled.
(Name of member/patient)

FROM _____ TO _____
(Initial date of disability) (Expected return to work date)

2. Is the claimant still disabled to the extent that he is unable to return to full duty work? Yes No

3. Diagnosis: _____

4. Date(s) of treatment: _____

Physician's Signature: _____ Date: _____

Name of Physician: _____ Degree: _____
(please print clearly)

Physicians Address: _____

Phone Number: _____ Fax Number: _____

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