WEEKLY INCOME CLAIM CONTINUATION FORM

NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN
PO BOX 476
NEWTOWN SQUARE, PA 19073-0476
Phone 1-800 252-4611 / Fax 610 557-4556

On a periodic basis, the National Elevator Industry Health Benefit Plan will request current information to support your claim for Weekly Income Benefits. Your attending physician must certify that you remain totally disabled and unable to work in order for your Weekly Income Benefits to continue. So that your Weekly Income Benefits continue uninterrupted, please have your attending physician complete and return this form (or provide their own disability certificate) to the above listed address or fax number as soon as possible.

If you anticipate returning to work earlier than expected, or if you have already returned to work, please provide us with this information by contacting our office at 1-800 252-4611.

Date: ___________________________________________________________________ _____________________
Patient Name: __________________________________________________________________ ______________
Member ID: ___________________________________________________________ _______________________

PHYSICIAN STATEMENT
(To be completed by the patient’s attending physician only)

Patient Name: _______________________________________________________________________________________
Nature of illness or injury: ____________________________________________________________________________

Date of first treatment: _______________________________________________________________________________

Date of last treatment: _______________________________________________________________________________
Nature of last treatment or surgical procedure: _______________________________________________________________

Date patient may return to work (if unknown at this time, please project): _________________________________

Patient has been disabled and unable to work from: __________________through: __________________________

Remarks: __________________________________________________________________________________________

Date: ___________________________ Physician Signature: _____________________________________________________

Print Name: __________________________________________ Degree: ___________________________

Address: ____________________________________________________________________________________________

Phone Number: __________________________ Fax Number: ________________________________