FRINGE BENEFIT FUNDS
LOCAL 14-14B

INTERNATIONAL UNION OF OPERATING ENGINEERS
141-57 NORTHERN BOULEVARD, FLUSHING, NY 11354
Telephone (718) 939-1489
Office Fax (718) 939-2034
Welfare Fax (718) 661-3584

CONTINUED CLAIM FOR DISABILITY BENEFITS

THE DOCTOR'S STATEMENT MUST BE FILLED IN COMPLETELY TO PREVENT DELAY IN THE PAYMENT OF DISABILITY BENEFIT PAYMENTS.

DOCTOR'S STATEMENT

1. Claimant's Name _____ 2. Age _____
   First Middle Last

3. Diagnosis: _____
   _____

4. Operation Indicated? ☐ YES ☐ NO a. Type _____ b. Date _____

5. Enter Dates for the following:
   a. Date of your first treatment for this disability _____
   b. Date of your most recent treatment for this disability _____
   c. Date Claimant was unable to work because of this disability _____
   d. Date Claimant will be able to perform usual work _____
   Even is considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.

6. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ☐ YES ☐ NO

Remarks: _____
_____

Physician's Name (please print) _____
Office Address _____
Number Street City/Town State Zip code

W.C.B. Authorization Registration No._____ W.C.B. Rating Code_____
Date _____ Physician's Signature_____

RETURN THIS FORM COMPLETED IN FULL ON OR AFTER_____

Claimant's Signature_____
Date_____