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

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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 the appropriate section of this form is completed and returned to the Fund Office.

Part 1: If you continue to be disabled, an up-to-date out of work excuse or Part 1 of this form must be completed by your physician.

1. Patient's full name _____ SSN or UID _____
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: If you have returned to work, this section must be completed by your employer.

Employee's Full Name_____ SSN or UID:_____

Name of Company _____ Phone No. _____

Date Returned to Work _____

Employer's Signature _____ Position_____ Date_____