



CHICAGO REGIONAL COUNCIL OF CARPENTERS HEALTH-WELFARE FUND

12 East Erie Street
Chicago, IL 60611
(312) 787-9455 . Option 3

2010 Attending Physician's Statement for Continuation of Coverage for a Physically or Mentally Disabled Dependent

Instructions: **Print Clearly in Ink.** The Disabled Dependent's physician must complete this form in full and sign it. The Participant must return this form, along with the Participant's Statement to the Fund Office in the enclosed envelope. **Failure to complete this form in full** will result in the form being returned to the participant and a delay of benefit payments for the disabled dependent.

Participant's Name: _____		Participant's SSN# or UID# (UID# is on BCBS I.D. Card) _____			
Dependent's Name: _____		Dependent's Date of Birth: _____			
Nature and degree of disabling condition. (Please furnish full diagnosis and be as detailed as possible.) 					
Date you first treated the Patient: _____/_____/_____ Month Day Year		Frequency of visits: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____ Please specify		When did you last treat the Patient? _____/_____/_____ Month Day Year	
What was the nature of the last treatment? 					
Extent of Disability (a) Is the patient able to manage an independent existence? <input type="checkbox"/> Yes <input type="checkbox"/> No (b) What are his/her limitations? Mental: _____ _____ Physical: _____ _____ (c) Has such disability existed continuously since before the patient attained age 19? <input type="checkbox"/> Yes <input type="checkbox"/> No (d) What type of work can this individual perform? _____ _____					
Remarks: 					
Signature of M.D.: _____		Dated: _____			
Print Name: _____		Phone Number: _____			
Street Address: _____					
City, State & Zip: _____					

