

**TOLEDO ELECTRICAL WELFARE FUND**  
**PO BOX 60408 – ROSSFORD, OH 43460 – 419-666-4450**

**CONTINUATION OF DISABILITY BENEFITS**

Disability income payments have been paid to you through: \_\_\_\_\_. You have received disability benefits for a total of \_\_\_\_\_ weeks \_\_\_\_\_ days. Maximum benefits not to exceed 26 weeks.

*You must complete this form to continue disability payments. Make sure all items are completely filled in.*

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**PHYSICIAN SECTION**

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Patient Name: \_\_\_\_\_

Nature of Disability: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of first treatment: \_\_\_\_\_ Date of most recent treatment: \_\_\_\_\_

If disability continues beyond \_\_\_\_\_, please indicate the anticipated date (not to exceed four weeks) the disability will end: \_\_\_\_\_

After the above date, will the patient be medically able to return to work? \_\_\_\_\_ If no, please indicate date of next evaluation: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date of Signature: \_\_\_\_\_

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**PARTICIPANT SECTION**

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Participant Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

From \_\_\_\_\_ to the disability end date indicated by your physician, have you or will you:

1. Receive any Unemployment Compensation benefits? \_\_\_\_\_
2. Receive any Workers' Compensation benefits? \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date of Signature: \_\_\_\_\_