



**CENTRAL STATES  
SOUTHEAST AND  
SOUTHWEST AREAS  
HEALTH AND WELFARE AND PENSION FUNDS**

Local Union
Claim No.

**LOSS OF TIME CLAIM FORM - REPORT OF CONTINUED DISABILITY**

Return Completed Form To: PO Box 5107 Des Plaines IL 60017-5107

or

Fax Form To: 847-518-9757

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Member ID: \_\_\_\_\_ Employer: \_\_\_\_\_

Full Name: \_\_\_\_\_ Address: \_\_\_\_\_

By signing below, I am certifying that I have not returned to work or retired:

Signature of Member \_\_\_\_\_ Member's Phone Number \_\_\_\_\_ Date \_\_\_\_\_

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Patient's Name: \_\_\_\_\_

Have any complications or other conditions arisen since the last medical update? Yes  No

If yes, please explain: \_\_\_\_\_

Please list all dates of treatment related to this disability:

Office visits: \_\_\_\_\_ Surgery/Hospital date(s): \_\_\_\_\_

**ACTUAL OR ESTIMATED RETURN TO WORK DATE REQUIRED**

**Actual** return to work date: \_\_\_\_\_ **OR** **Estimated** return to work date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Print Physician's Name: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_ Date form completed: \_\_\_\_\_

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**THIS SECTION REQUIRED ONLY IF MEMBER HAS RETURNED TO WORK**

What date did the employee actually return to work? \_\_\_\_\_ Please verify the last day of work? \_\_\_\_\_  
(Do not use a future date)

Employer Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Employer Phone Number: \_\_\_\_\_ Date form Completed: \_\_\_\_\_

# Loss of Time Continuation Form

## General Information

- **Please do not use this form to report a new period of disability.** The Initial Report of Disability Form must be completed for *each new period* of time off work.
- Once Loss of Time benefits begin, we will notify you of the date payments end. You may be asked to submit an additional Continuation Form if you need further Loss of Time benefits. To obtain a Continuation Form, contact our Toll-Free Department at 1-800-323-5000 or visit our website at [www.centralstates.org](http://www.centralstates.org).

*UPS members:* If you exhaust your 26 weeks of Loss of Time Benefits, you may be eligible for long-term disability benefits through UPS. To determine your eligibility, please call 1-877-638-4877.

*Non-UPS members:* If you exhaust your 26 weeks of Loss of Time Benefits, you may be eligible to make Self-Payments or receive an Extension of Benefits to continue health and welfare coverage. Please contact our Toll-Free Department at 1-800-323-5000 if you need further information.

## Physician's Supplementary Statement

- If the physician extended your return to work date since your last medical update, your physician should provide an explanation to support the change in your condition, as noted on the front of this form. Additional supporting documentation, such as the physician's office notes, may be required.
- All dates of treatment since the last report are required. Regular medical care is required to receive Loss of Time Benefits. If regular treatment is not needed, please ask your physician to submit an explanation.
- An actual or estimated date for your return to work is required. If left blank or stated as unknown, automatic payments will be affected.

## Employer's Statement

- Employer's Statement is only required if you have returned to work.

**Please call 1-800-323-5000 if you return to work prior to the date given by your doctor.**