JOINT BENEFIT TRUST
MAJOR MEDICAL EXTENSION FOR TOTAL DISABILITY

TO BE COMPLETED IN ADDITION TO REGULAR FORMS

CLAIMANT'S STATEMENT

(To Be Completed By Employee—Not His Dependent)

1. Employee's Name _____ I.D. # _____
2. Address _____
3. Dependent's Name _____
4. Employer _____ Local _____
5. Has disability ceased? _____ If "Yes" as of what date _____
6. Are you eligible for medical coverage under any other group plan? _____

Employee's Signature _____ Date _____

CERTIFICATION OF TOTAL DISABILITY

(To Be Completed By Attending Physician)

1. Patient's Name _____ Date of Birth _____
2. Usual occupation (if patient is not normally in employment give regular duties; i.e. housewife, schoolchild, etc.)

   _____
3. Nature of sickness or injury (describe complications, if any) _____

   _____

   _____
4. Was patient hospitalized? _____ Name of Hospital and City _____

   Date of onset: _____ Date of first treatment: _____

   Date of most recent treatment: _____ Frequency of treatment: _____
5. Period Confined: From _____ To _____
6. Condition prevented patient from engaging in any occupation, or all regular and customary duties:

   From _____ To _____
7. Extent of Disability:

   (a) Is patient now totally disabled for his own occupation?_____ Is patient now totally disabled for any other occupation? _____

   (b) Date patient did or will resume work: Regular occupation_____ Indefinite _____ Never _____

   Other occupation _____ Indefinite _____ Never _____

   (c) If patient will return to work with restriction or limitation, please describe and indicate how long it will be imposed:

   _____
8. Did this sickness or injury arise out of patient's employment? _____ If "Yes" please explain _____

   _____

Signature _____, M.D. Date _____
Address _____
Phone Number _____

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