STATUS REPORT FOR CONTINUING LOST TIME BENEFIT

ATTENDING PHYSICIAN'S SUPPLEMENTARY REPORT

name of employee ____________________ group policy number ____________

name and address of employer ____________________ claim number ____________

WE NEED THIS REPORT IN ORDER TO FURTHER CONSIDER YOUR CLAIM FOR PAYMENT

TO BE COMPLETED BY EMPLOYEE

date ____________ ☐ **RESUMED WORK** ☐ **EXPECTED TO RESUME WORK**

employee's signature ____________ date signed ____________

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. NATURE OF SICKNESS OR INJURY (describe complications, if any): ____________________

2. GIVE DATES OF TREATMENT: date of first treatment ____________ date of most recent treatment ____________ frequency of treatments ____________

3. THE PATIENT HAS BEEN CONTINUOUSLY DISABLED (unable to work) FROM ____________ THROUGH ____________

   IF STILL DISABLED, WHEN SHOULD PATIENT BE ABLE TO RETURN TO WORK? ____________

4. REMARKS: ____________________

please print or type attending physician's name ____________ degree ____________

address ____________________

city-state-zipcode ____________ phone ____________ attending physician's signature ____________ date ____________

RETURN COMPLETED FORM TO:

NORTHERN MN-WI AREA RETAIL FOOD HEALTH & WELFARE FUND
2002 London Road, Ste. 300, Duluth, MN 55812, Phone 218-728-4231
MN TOLL FREE 1-800-570-1012, Fax 218-728-4773