ATTENTION: Weekly disability benefits will terminate as of _____
if this form is not completed by the Attending Physician and returned to the Fund Office.

To extend your disability benefits, your Attending Physician must complete and return this form to:

IRON WORKERS BENEFIT TRUST
1470 WORLDWIDE PLACE • VANDALIA, OHIO 45377 - 1156
Phone (937) 454-1744 • Toll Free: (800) 331-4277 • FAX (937) 454-5457
www.iwtrustfund.com

ATTENDING PHYSICIAN'S EXTENSION OF DISABILITY

IRONWORKER COMPLETE THIS SECTION: TO AVOID DELAY CLAIM FORM MUST BE FULLY COMPLETED

LAST NAME, FIRST NAME	SOCIAL SECURITY #	AREA CODE & PHONE	DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.

X **IRONWORKER SIGNATURE** **DATE**

ATTENDING PHYSICIAN COMPLETE THIS SECTION: TO AVOID DELAY CLAIM FORM MUST BE FULLY COMPLETED

DIAGNOSIS AND CONCURRENT CONDITIONS

DATES OF SERVICE
(If previous form submitted to this carrier, you need show only dates since last report)

PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (Unable to work).	IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK
From Thru	

PHYSICIAN'S NAME (Print)	DATE	SIGNATURE	DEGREE	TELEPHONE

Must be signed by the original disabling physician. X

STREET ADDRESS	CITY OR TOWN	STATE	ZIP CODE

REMARKS: