SHEET METAL WORKERS' LOCAL NO. 33
SUPPLEMENTAL UNEMPLOYMENT BENEFIT FUND

P.O. Box 4450 / Troy, MI 48099-4450
1 (800) 851-6024 / (248) 556-2593 fax
Email address: smw33@subfund.org

STATEMENT OF CONTINUANCE OF DISABILITY

INSTRUCTIONS: This form must be submitted by the individual employee to the Fund Office at the above address, properly and fully completed and signed by the participant and the physician.

1. What is your full name? _____

2. What is your home address?_____

   _____

3. Are you still totally disabled by this sickness or injury? _____

4. Are you now unable to physically engage in any work, occupation or business? _____

5. On what date were you last treated by a physician?_____

6. Have you returned to work?_____ If so on what date?_____

7. Is this sickness or accident work related? _____

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

1. Patient's name:_____

2. Diagnosis:_____

3. Date of first treatment: _____ Date of most recent treatment: _____

4. The patient has been continuously disabled (unable to work) from _____

   If disabled, when should the patient be able to return to work? _____

5. Remarks: _____

Date:_____ Signed:_____
(Attending Physician)

Address:_____

_____

Phone:(_____)_____