U.A. LOCAL 393 SHORT TERM DISABILITY EXTENSION

Return Completed Form To:
U.A. LOCAL 393
P.O. Box 2460
San Jose, CA 95109
Fax: (408) 436-8210

Before additional disability benefits can be considered, it is necessary that your doctor complete this extension form and return it to the fund office at the above address or fax number. Upon receipt of the completed form, we will give your claim our immediate attention. If you have returned to work, please contact the Fund office to report the date you returned to work.

Patient Name/Social Security #:

Diagnosis (ICD 9):

First Date of Treatment:

Date of Next Treatment:

First Date of Disability:

Return to Work Date (give tentative date if unsure.):

Remarks:

Physician Signature: _____ Tax ID: _____

Address: _____
_____
_____

Telephone: _____ Date: _____