RETURN FORM TO: J.W. Terrill | a Marsh & McLennan Agency LLC company
825 Maryville Centre Drive, Suite 200
Chesterfield, MO 63017
FAX: 866-731-9962
EMAIL: jwtclaims@jwterrill.com

ST. LOUIS GRAPHIC ARTS JOINT HEALTH AND WELFARE FUND
DISABILITY CONTINUATION FORM

PATIENT'S NAME	SOCIAL SECURITY NUMBER (SSN)	BIRTHDATE

DIAGNOSIS AND CONCURRENT CONDITIONS, INCLUDING ICD-10 OR DSM-III CODE.

LIST ALL TESTS PERFORMED AND DATES OF SERVICE THAT HAVE NOT BEEN PREVIOUSLY REPORTED:

_____

_____

PROVIDE SURGICAL PROCEDURES PERFORMED RELATED TO THIS CONDITION THAT HAVE NOT BEEN PREVIOUSLY REPORTED:

_____

☐ INPATIENT ☐ OUTPATIENT DATE(S) OF PROCEDURE(S): _____

IF PATIENT WAS INPATIENT, PROVIDE DATES HOSPITLIZED:_____

NAME AND ADRESS OF HOSPITAL_____

DATES OF SERVICE THAT HAVE NOT BEEN PREVIOUSLY REPORTED. INCLUDE DATE OF NEXT APPOINTMENT:

OFFICE VISITS:_____

HOME VISITS:_____

HOSPITAL VISITS:_____

NEXT SCHEDULED APPOINTMENT:	PROVIDE THE DATE THE PATIENT SHOULD BE ABLE TO RETURN TO WORK:

IF PATIENT IS NOT ABLE TO RETURN TO WORK, WHAT CONDITIONS/RESTRICTIONS ARE PREVENTING RETURNING TO WORK?

IF PATIENT WILL NOT BE ABLE TO RETURN TO HIS/HER OWN OCCUPATION, WILL PATIENT BE ABLE WORK AT ANY OCCUPATION?
☐ Yes ☐ No IF "NO" PLEASE PROVIDE CONDITIONS/RESTRICTIONS THAT WILL PREVENT HIM/HER FROM WORKING AT ANY OCCUPATION:

PHYSICIANS NAME (PRINT) SIGNATURE	DEGREE

SOCIAL SECURITY NUMBER	TAX IDENTIFICATION NUMBER	EMAIL ADDRESS:

STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE

PHONE NUMBER:	FAX NUMBER:

_____	_____
SIGNATURE	DATE