

# Continuance of Disability

NATIONAL EMPLOYEES  
HEALTH PLAN

It is required that periodic reports be submitted for continuance of disability benefits. No further payments will be considered until this report is completed and received in the claims processing center.

## Employee Statement

Employee Name: \_\_\_\_\_ Participant ID: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Local Union No.: \_\_\_\_\_

## Claim Information

Have you returned to any employment? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, give date: \_\_\_\_\_

If not, on what date will you be able to return to your employment? \_\_\_\_\_

What prevents you from returning to your employment? \_\_\_\_\_

Name and address of all physicians' treating you during this disability: \_\_\_\_\_

### To Whom it May Concern

I hereby authorize any hospital, physician, employee, insurance company, or any other organization to release to National Employees Health Plan or its authorized representative, any and all information you may have with respect to any sickness or injury, including past and present medical history, diagnoses, consultations, prescriptions, examinations, treatment, operative procedures, X-rays and pathological findings. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

## Employer Statement

Company Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation of Employee: \_\_\_\_\_ Has employee returned to work? Yes \_\_\_\_\_ No \_\_\_\_\_

Date employee last worked: Month: \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Time \_\_\_\_\_ a.m./p.m.

Date employee returned to work: Month: \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Time \_\_\_\_\_ a.m./p.m.

Regularly employed and actively working when disabled? Yes \_\_\_\_\_ No \_\_\_\_\_

Was disability caused by employment? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, has a claim been filed or will a claim be filed under worker's compensation: Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Printed Employer Name Representative

\_\_\_\_\_  
Employer Signature Representative

\_\_\_\_\_  
Official Title

\_\_\_\_\_  
Date

**Please forward completed form to:**

National Employees Health Plan • P.O. Box 37502 • Oak Park, MI 48237-0502  
In Michigan call 1-586-693-4400 • Outside of Michigan call 1-800-447-1032 • Fax 586-693-4820

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## Attending Physician's Statement

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Diagnosis and concurrent conditions (if diagnosis code other than "ICDA" used, give name): \_\_\_\_\_  
\_\_\_\_\_

2. Report of Services (If previous form submitted to this carrier, you need only show dates since last report)

Date of Service	Place of Service	Description of Surgical or Medical Services Rendered
_____	_____	_____
_____	_____	_____
_____	_____	_____

\* Place of Service Codes:

(O) Doctor's Office / (IH) Inpatient Hospital / (NH) Nursing Home / (H) Patient's Home / (OH) Outpatient Hospital / (OL) Other Locations

3. Is patient still under your care for this condition: Yes \_\_\_ No \_\_\_

4. Dates patient was continuously totally disabled (unable to work): From: \_\_\_\_\_ To: \_\_\_\_\_

5. Dates patient was partially disabled: From: \_\_\_\_\_ To: \_\_\_\_\_

6. If still disabled, date patient should be able to return to work (mm/dd/yy): \_\_\_\_\_

7. If partially disabled, list restrictions: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Printed Name / Type of Degree

\_\_\_\_\_  
Tax ID or Social Security Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Telephone Number

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