1199SEIU National Benefit Fund

Disability Department, 498 Seventh Avenue, 8th Floor, New York, NY 10018-0009 • www.1199SEIUFunds.org
Fax: (646) 473-6764, (646) 473-6768 or (646) 473-6769 • Email: DBLClaims@1199Funds.org

SUPPLEMENTAL MEDICAL INFORMATION GENERAL

This form is strictly confidential. **Please print clearly in black or blue ink.**
This form must be completed and returned to the Funds so that disability benefits can continue without interruption.

MEMBER'S FULL NAME | MEMBER'S JOB TITLE | MEMBER'S ID #

PRIMARY DIAGNOSIS

SECONDARY DIAGNOSES AND OPERATIVE PROCEDURES (IF ANY)

EXAMINATION PERFORMED AND POSITIVE FINDINGS RELEVANT TO DISABILITY:

PHYSICAL EXAMINATION

REVIEW OF:

A. X-ray report(s): _____ **B.** Surgical report(s): _____

C. Laboratory results: _____ **D.** Other test(s): _____

If patient is not able to return to work, explain briefly and precisely how positive findings prevent the patient from performing his or her usual work:

Please list any suggestions for work modification, different therapy or a prognosis for chronic or recurrent conditions (use additional pages if necessary):

Dates of treatment: _____

THE FOLLOWING ADDITIONAL REPORTS ARE REQUIRED (IF NECESSARY):

☐ Hospital discharge summary
☐ Surgeon's operative report
☐ Other (specify): _____

AS A RESULT OF THIS EXAMINATION AND THE DATA AVAILABLE, I FIND THIS INDIVIDUAL:

☐ Able to return to work
☐ Not able to return to work

Anticipated date of return to work: _____ (Please give your best estimate, even if prognosis is uncertain.)
MM/DD/YYYY

PHYSICIAN'S NAME | SPECIALTY

SOCIAL SECURITY #/TIN | PHONE NUMBER

ADDRESS | CITY | STATE | ZIP CODE

X _____
PHYSICIAN'S SIGNATURE (REQUIRED) **DATE (REQUIRED)**