IBEW LOCAL UNION NO. 654
HEALTH & WELFARE FUND
c/o Frank M. Vaccaro & Associates, Inc.
27 Roland Avenue, Suite 200
Mount Laurel, NJ 08054

APPLICATION – CONTINUING ELIGIBILITY

Member's Name: _____
Social Security #: _____ Birth Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Last Employer: _____ Last Day Worked: _____
Nature of Sickness or Injury: _____
Date Accident Occurred or Sickness Began: _____
If Injured, How and Where Did Accident Happen? _____
_____
Date of First Treatment: _____
Name of Doctor: _____ Address: _____
Name of Hospital: _____ From: _____ To: _____
Are You Filing Claim Under Any Workmen's Compensation Law?: _____
Are You Collecting Unemployment Compensation?: _____ From Which Office? _____
Expected Return to Work Date: _____

Date: _____ Signed: _____

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: _____
Nature of Sickness or Injury (Describe Complications, If Any): _____
_____
Is this Sickness or Injury related to the Patient's Employment?: Yes _____ No _____
If "YES", Explain: _____
_____
Give Dates of Treatment:
Initial Treatment Date: _____ Most Recent Treatment Date: _____
Initial Hospital Date: _____ Most Recent Hospital Date: _____
The Patient Has Been Continuously Disabled (Unable to Work):
From: _____ Through: _____
If Still Disabled, When Would Patient Be Able to Return to Work: _____
Physician's Signature: _____ Date: _____
Physician's Address: _____
City: _____ State: _____ Zip Code: _____

CLAIM FORM MUST BE SIGNED AS A TESTAMENT TO ACCURANCY BY PARTICIPANT AND PHYSICIAN