



**CENTRAL STATES
SOUTHEAST AND
SOUTHWEST AREAS
HEALTH AND WELFARE AND PENSION FUNDS**

**IF ALL REQUIRED INFORMATION IS NOT SUBMITTED, YOUR
REQUEST FOR AN EXTENSION WILL BE DELAYED**

MEMBER SS# _____ MEMBER NAME _____ MEMBER DOB _____
STREET ADDRESS _____ CITY/STATE/ZIP CODE _____

****NOTE**EXTENDED COVERAGE IS AVAILABLE ONLY IF CERTAIN CRITERIA IS MET AND IT IS LIMITED. THE BENEFITS ARE ONLY FOR THE PERSON WHO IS TOTALLY DISABLED AND COVERS ONLY THE SPECIFIC MEDICAL CONDITION THAT HAS TOTALLY DISABLED THEM. ANOTHER OPTION AVAILABLE TO CONTINUE COVERAGE FOR YOU AND/OR YOUR ELIGIBLE DEPENDENTS IS BY MAKING COBRA SELF-PAYMENTS, INFORMATION HAS BEEN OR WILL BE SENT FOR COBRA.**

TO BE COMPLETED BY THE MEMBER

1. IS YOUR SPOUSE EMPLOYED? YES NO, IF YES, PROVIDE THE FOLLOWING.
NAME/ADDRESS OF SPOUSE'S EMPLOYER _____
NAME/ADDRESS OF SPOUSE'S INSURANCE CARRIER _____

****NOTE**IF THERE IS NO INSURANCE, OR IF THE DISABLED INDIVIDUAL IS NOT COVERED UNDER THE ABOVE INSURANCE, YOU MUST SEND EITHER A LETTER FROM THE EMPLOYER, OR A LETTER FROM THE INSURANCE CARRIER VERIFYING NO INSURANCE COVERAGE AND THE REASON FOR NO COVERAGE.**

2. ARE YOU COVERED UNDER ANY OTHER INSURANCE PLAN? YES NO
IF YES, NAME AND ADDRESS OF INSURANCE _____
3. HAVE YOU OR DISABLED INDIVIDUAL APPLIED FOR A SOCIAL SECURITY DISABILITY AWARD? YES NO
IS THE DISABLED INDIVIDUAL ENTITLED TO A SOCIAL SECURITY AWARD? YES NO
IF NO, HAS THE DISABLED INDIVIDUAL APPEALED THE DECISION? YES NO
ARE YOU ELIGIBLE FOR MEDICARE? YES NO

****NOTE**YOU MUST INCLUDE COPIES OF ALL DOCUMENTS THAT APPLY TO QUESTION #3 SUCH AS, YOUR SOCIAL SECURITY AWARD OR DENIAL, A STATEMENT FROM YOUR SOCIAL SECURITY ADMINISTRATION REGARDING THE STATUS OF YOUR CLAIM OR APPEAL, AND A COPY OF YOUR MEDICARE CARD.**

I CERTIFY THAT ALL OF THESE STATEMENTS ARE TRUE AND CORRECT

MEMBER SIGNATURE _____ DATE _____

TO BE COMPLETED BY YOUR ATTENDING PHYSICIAN

****IN ORDER TO PROCESS OUR PARTICIPANT'S REQUEST FOR EXTENSION OF BENEFITS, WE NEED A CURRENT STATEMENT FROM AN ATTENDING PHYSICIAN REGARDING THEIR DISABLING CONDITION.**

PLEASE COMPLETE ALL INFORMATION AND RETURN THIS LETTER TO OUR OFFICE AT YOUR EARLIEST CONVENIENCE.

1. IS PATIENT DISABLED FROM WORK & NORMALACTIVITY_____
2. DISABLING DIAGNOSIS_____
3. EXTENT/DEGREE OF DISABILITY _____
4. PROGNOSIS _____
5. ANTICIPATED LENGTH OF DISABILITY ALONG WITH TREATMENT PLAN _____

PHYSICIAN SIGNATURE_____ DATE_____

SUBMIT ALL COMPLETED INFORMATION TO: CENTRAL STATES H & W FUND, P.O. BOX 5107 DES PLAINES, IL 60017-5107