RETURN FORM TO:

DUES MUST BE PAID CURRENT

Benefit is $20.00/week for a max benefit of 12 weeks

BROTHERHOOD OF TEAMSTERS LOCAL UNION NO. 70

400 Roland Way • Oakland, CA 94621 • 510-569-9317 • Fax 510-569-1906

CERTIFICATE OF ILLNESS/SICK BENEFITS FORM

NAME: _____ SS#: _____

ADDRESS: _____ CITY _____ ZIP _____

EMPLOYER: _____ PHONE: _____ EMAIL: _____

Date of Illness or Injury: _____ Date Last Worked: _____

PHYSICIAN'S PORTION

I hereby certify that member _____ has been ill and under my care from _____ to _____ ,20_____ suffering from _____.

Condition at this time is _____. Was it chronic? _____ Date when patient will be able to follow his usual vocation? _____ Did he/she, while under your care perform any kind of work? _____ If so, what _____? In your opinion is he entitled to sick benefits? _____

Is he/she still under your care? _____ **Probable date of recovery** _____(MM/DD/YY)

Please complete and return to this office by _____.

Physician's Address: _____Phone: _____

Signature of attending physician _____.

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LOCAL UNION'S PORTION

APPROVED BY: _____ **APPROVED BY:** _____ **APPROVED BY:** _____

Week No.	New Claim	Continuation 1	Continuation 2
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
PAID			
DATE			
CHECK#			