



Continuing Disability Statement

For MCC Use Only

Date sent *MM/DD/YYYY*

Date received *MM/DD/YYYY*

Employer Information *All sections to be completed in full.*

Unit name		Unit number	####
Address		Street address or PO box, city, state, and zip code	Phone (###) ###-####

Employee Information

Full name		Last, first, and middle	SSN	###-##-####
Address		Street address or PO box, city, state, and zip code	Phone	(###) ###-####

Since your last report has there been any change in physician(s) consulted? Yes No *If 'Yes,' provide details requested below.*

Physician name				
Address		Street address or PO box, city, state, and zip code	Phone	(###) ###-####

Since your last report, have you had any surgery? Yes No *If 'Yes,' provide details requested below.*

Hospital name		Date admitted	<i>MM/DD/YYYY</i>	Date released	<i>MM/DD/YYYY</i>	
Address						Street address or PO box, city, state, and zip code
Type of surgery performed				Date performed		<i>MM/DD/YYYY</i>

Have you returned to work? Yes (Full Time) Yes (Part Time) No *If 'Yes,' provide details requested below.*

Date	<i>MM/DD/YYYY</i>	Earnings	\$
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Does your employer have a job for you to go back to? Yes No

Have you applied for or are you currently looking for employment? Yes No *If 'Yes,' provide type of occupation applied for.*

Type of occupation applied for

Since your last report, have you applied for or are you receiving income from any other source as a result of your present disability?

Yes (Applied For) Yes (Received) No *If 'Received,' provide details requested below. If 'Other,' please specify.*

Type of benefit:	<input type="checkbox"/> Auto insurance	<input type="checkbox"/> Pension plan	<input type="checkbox"/> Retirement	<input type="checkbox"/> Other:			
	<input type="checkbox"/> State Disability	<input type="checkbox"/> Social Security	<input type="checkbox"/> Workers' compensation				
Amount of benefit	Received:	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	Date benefit began	<i>MM/DD/YYYY</i>	Date benefit ends	<i>MM/DD/YYYY</i>
\$		<input type="checkbox"/> Biweekly	<input type="checkbox"/> Lump sum				

Prohibition Against the Commission of Fraud / Authorization for Release of Medical Information *Both parties must sign and date this form for it to be valid.*

PLEASE BE AWARE: Certain states regulate and have laws concerning any person who knowingly and with intent to defraud any company files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact, material hereto, commits a fraudulent act, which is a crime, subject to criminal prosecution and civil penalties. **A facsimile or photocopy of this release shall be as valid as if it were an original.**

I hereby authorize any hospital, physician, medical practitioner, clinic, medical facility, pharmacy, employer or insurance company to release any and all reports or information with respect to the medical history, physical condition and treatment rendered to this claimant; and, if required, to permit them or any person appointed by them to examine any and all X-rays or records regarding the physical condition of or treatment rendered to the Plan Administrator, the Michigan Catholic Conference.

Employee signature	Date	<i>MM/DD/YYYY</i>
Employer signature	Date	<i>MM/DD/YYYY</i>



Attending Physician's Supplementary Statement

Patient Information <i>All sections to be completed in full.</i>	
Patient name	
Diagnosis	
Describe complications or new independent conditions which may affect the patient's duration of disability	
Date of last visit <i>MM/DD/YYYY</i>	Estimated frequency of future visits or date of next visit: <input type="checkbox"/> Weekly <input type="checkbox"/> Other: <input type="checkbox"/> Monthly
Have you been actively supervising this patient's care during the full period? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If 'No', comment below in 'Remarks.'</i>	
To the best of my knowledge, the patient is totally disabled (unable to work). <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If 'Yes', provide reason and approximate date patient should be able to return to work. If 'No', provide reason and approximate date patient could have returned to work.</i>	
Reason	Date <i>MM/DD/YYYY</i>
Was or is the patient partially disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If 'Yes', provide how long the patient was or will be partially disabled.</i>	
Date from <i>MM/DD/YYYY</i>	Date to <i>MM/DD/YYYY</i>
Is the patient a suitable candidate for a rehabilitation program? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If 'Yes', provide type of program.</i>	
Type of program	
Remarks	
Physician Information	
Physician name	Specialty
Address <i>Street address or PO box, city, state, and zip code</i>	Phone <i>(###) ###-####</i>
Physician Signature <i>Please return completed form to the patient. The patient is responsible for securing this form and for charges made for its completion.</i>	
Physician signature	Date <i>MM/DD/YYYY</i>