MICHIGAN CATHOLIC CONFERENCE

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 MM/DD/YYYY	Date released MM/DD/YYYY
Address *Street address or PO box, city, state, and zip code*		
Type of surgery performed		Date performed MM/DD/YYYY

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

Date MM/DD/YYYY	Earnings $

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: ☐ Auto insurance ☐ State Disability ☐ Pension plan ☐ Social Security ☐ Retirement ☐ Workers' compensation ☐ Other:

Amount of benefit $	Received: ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Lump sum	Date benefit began MM/DD/YYYY	Date benefit ends MM/DD/YYYY

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 MM/DD/YYYY
Employer signature	Date MM/DD/YYYY

Rev. 12/6/19

Questions? Please contact Michigan Catholic Conference by phone at (800) 395-5565, fax to (517) 316-3690, or mail to 510 South Capitol Avenue, Lansing, Michigan 48933.
Visit us on the web at www.micatholic.org

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Attending Physician's Supplementary Statement

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

Patient name

Diagnosis

Describe complications or new independent conditions which may affect the patient's duration of disability

Date of last visit *MM/DD/YYYY*

Estimated frequency of future visits or date of next visit: ☐ Weekly ☐ Monthly ☐ Other:

Have you been actively supervising this patient's care during the full period? ☐ Yes ☐ No *If 'No', comment below in 'Remarks'.*

To the best of my knowledge, the patient is totally disabled (unable to work). ☐ Yes ☐ No
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.

Reason

Date *MM/DD/YYYY*

Was or is the patient partially disabled? ☐ Yes ☐ No *If 'Yes', provide how long the patient was or will be partially disabled.*

Date from *MM/DD/YYYY*

Date to *MM/DD/YYYY*

Is the patient a suitable candidate for a rehabilitation program? ☐ Yes ☐ No *If 'Yes', provide type of program.*

Type of program

Remarks

Physician Information

Physician name

Specialty

Address *Street address or PO box, city, state, and zip code*

Phone *(###) ###-####*

Physician Signature *Please return completed form to the patient. The patient is responsible for securing this form and for charges made for its completion.*

Physician signature

Date *MM/DD/YYYY*

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