TEAMSTERS HEALTH AND WELFARE FUND
2500 McCLELLAN AVENUE, SUITE 140 · PENNSAUKEN NJ 08109 · PHONE NO.# 856-382-2400 · FAX NO. #856-382-2402
WEEKLY DISABILITY BENEFIT CLAIM FORM

DIRECTIONS FOR COMPLETING FORM

Complete Section #1, Claimant's portion of this form. **YOU ARE REPONSIBLE** for having Section #2 completed by your doctor and Section #3 completed by your employer. **Any missing or incorrect information on this form will delay processing of your claim.**

PLEASE NOTE: ALL SECTIONS OF THE CLAIM FORMS MUST BE RECEIVED IN ORDER TO PROCESS YOUR CLAIM.

COMPLETED APPLICATIONS CAN BE FAXED TO: 856-382-2402

Read all questions carefully! Print or write clearly since this information is used to determine your right to benefits. If you need any assistance in completing this form, please call the Member Services Department at 856-382-2400, Option 1.

- Report of Continued Disability Forms are required to be completed approximately once a month by the member, physician, and employer. All claims will be placed on hold until the Report of Continued Disability Form is returned.

- Your signature certifies that you understand that any misrepresentation of fact or failure to disclose a material fact may be punishable under the law and may result in a forfeiture of benefits under the Plan. This includes any changes to the Medical Certificate or the Employer's Statement made by you without authorization by your physician or your employer benefits.

- You must inform us of any other payments you are receiving such as sick pay or wages, a pension from your last employer, worker's compensation benefits, Social Security Disability benefits, or unemployment.

IMPORTANT: We suggest you keep a copy of the completed form for your records.

***** TO INSURE TIMELY PROCESSING OF YOUR CLAIM, ALL PAPERWORK MUST BE RECEIVED BY TUESDAYS BY 5:00 PM *****

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SECTION I - INFORMATION TO BE COMPLETED BY CLAIMANT (MEMBER)

1. NAME: FIRST_____ MI ____ LAST _____
2. SOC.SEC.NO:_____
3. DATE OF BIRTH: _____
4. CIRCLE ONE: MALE FEMALE
5. ADDRESS: STREET _____

   CITY, STATE _____ ZIP CODE _____
6. HOME PHONE#:_____
7. NAME OF EMPLOYER: _____
8. EMPLOYERS PNONE NO. #:_____
9. EMPLOYERS ADDRESS _____

   _____
10. IS THIS A CLAIM FOR (CIRCLE ONE): ACCIDENT ILLNESS
11. IF THIS IS AN ACCIDENT CLAIM: WHERE DID ACCIDENT OCCUR? _____

    _____

    DATE OF ACCIDENT: _____

    EXPLAIN ACCIDENT IN DETAIL: _____

    _____

    _____

    _____

    _____

    _____

    _____
12. WAS CONDITION RELATED TO (CIRCLE ONE): WORK RELATED AUTOMOBILE ACCIDENT SURGERY HOSPITALIZATION OTHER 3RD PARTY INVOLVEMENT OTHER
13. DATE OF EMERGENCY ROOM CARE_____

    DATE OF SURGERY: _____

    HOSPITALIZATION: FROM _____ TO _____
14. ARE YOU/HAVE YOU APPLIED FOR UNEMPLOYMENT BENEFITS? IF YES, PLEASE GIVE EFFECTIVE DATE_____
15. HAVE YOU APPLIED/ARE YOU APPLYING FOR FMLA BENEFITS?

    _____ YES _____ NO

    a. IF YES, PLEASE PROVIDE THE EFFECTIVE DATE: _____
16. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY OR EMPLOYER INFORMATION NECESSARY TO PROCESS THIS WEEKLY DISABILITY CLAIM.

MEMBER SIGNATURE HERE: _____ DATE: _____

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SECTION II – ATTENDING PHYSICIAN'S STATEMENT (TO BE COMPLETED BY YOUR DOCTOR)

1. PATIENT'S NAME:_____DOB _____
2. ICD-10 CODE :_____DIAGNOSIS & CONCURRENT CONDITION

   _____

   _____

   _____
3. DATE SYMPTOMS FIRST APPREARED: _____
4. IS/WAS EMERGENCY ROOM CARE OR HOSPITALIZATION REQUIRED: (CIRCLE ONE) YES NO

   4a. IF YES: PROVIDE DATE FOR EMERGENCY ROOM: _____

   4b. IF YES: HOSPITALIZED FROM _____ TO _____
5. IS/WAS OPERATION INDICATED: (CIRCLE ONE) YES NO

   5a. IF YES: OPERATION PERFORMED/TO BE PERFORMED _____
6. DATE OF YOUR FIRST TREATMENT FOR THIS DISABILITY_____
7. DATES OF TREATMENT SINCE FIRST TREATMENT TO PRESENT

   _____

   _____

   _____

   _____
8. DATES OF TOTAL DISABILITY: FROM _____ TO _____
9. DATE PATIENT WILL BE ABLE TO RETURN TO WORK FULL DUTY: _____
10. DATE PATIENT WILL BE ABLE TO RETURN TO WORK LIGHT DUTY: _____

10a. IF RELEASED FOR LIGHT DUTY ONLY, PLEASE LIST RESTRICTIONS BELOW IF ANY

   _____

   _____

   _____

   _____

11. IN YOUR OPINION WAS THIS DISABILITY (SELECT ONE)

    OCCUPATIONAL SICKNESS/ACCIDENT AUTOMOBILE ACCIDENT OTHER

    IF OTHER PLEASE EXPLAIN: _____

   _____

   _____

   _____

   _____

PHYSICIAN'S NAME: _____ DEGREE _____
SPECIALTY_____
ADDRESS: _____
CITY/STATE _____ ZIP CODE _____
TELEPHONE NO. _____ TAX ID # _____
SIGNATURE: _____ DATE _____

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SECTION III - COMPANY STATEMENT (TO BE COMPLETED BY EMPLOYER ONLY)

1. EMPLOYEE'S NAME: _____SSN _____
2. DATE EMPLOYED: _____
3. EMPLOYEE'S OCCUPATION: _____
5. EMPLOYEE'S AVG WEEKLY SALARY (DOLLAR AMT.): $_____
6. DATE EMPLOYEE LAST WORKED: _____ TIME OF DAY: _____
7 REASON FOR STOPPING WORK: _____

_____

_____

_____

_____

8. IS ANY OF THIS TIME AFTER EMPLOYEE LAST WORKED PAID VACATION? _____YES _____NO
   IF YES, SPECIFY DATES:_____
   IS ANY OF THIS TIME AFTER EMPLOYEE LAST WORKED PAID SICK TIME OR HOLIDAY PAY?
   _____YES _____NO
   IF YES, SPECIFY DATES: _____
9. DATE EMPLOYEE RETURNED TO WORK FULL DUTY: _____
   LIGHT DUTY: _____
10. IS THIS ACCIDENT OR SICKNESS DUE TO EMPLOYMENT? _____ YES _____ NO
    a. IF YES, PROVIDE DATE OF ACCIDENT: _____
    b. PROVIDE DATE ACCIDENT WAS REPORTED TO EMPLOYER:_____
    c. HAS EMPLOYER APPLIED FOR WORKER'S COMPENSATION: _____ YES _____ NO
11. PRIOR TO THIS DISABILITY WAS THE EMPLOYEE (SELECT ONE)
    ACTIVELY WORKING LAID OFF ON LEAVE RETIRED DISCHARGED
12. HAS THE MEMBER/IS THE MEMBER APPLIED FOR FMLA? _____ YES _____ NO
    a. IF YES, PLEASE PROVIDE THE EFFECTIVE DATE: _____
13. IS/HAS THE MEMBER APPLIED/COLLECTING UNEMPLOYMENT BENEFITS? _____YES _____ NO
    a. IF YES, PLEASE PROVIDE THE EFFECTIVE DATE: _____
14. COMPANY NAME: _____
    ADDRESS:_____
15. DATE: _____ SIGNED BY: _____
    TITLE_____
16. PHONE NO.#: _____ EXTENSION: _____ FAX NO.#: _____