Teamsters Joint Council No. 83 of Virginia Health & Welfare and Pension Funds

www.tjc83funds.org
8814 Fargo Road · Suite 200 · Richmond, VA 23229
Phone (804) 282-3131 · 800-852-0806 · Fax (804) 288-3530
Email: documents@tjc83funds.net

DISABILITY CLAIM FORM

To file a claim:

1. ***Complete Section 1 (must be completed by participant)***
2. ***Have your employer complete Section II.***
3. ***Have your physician, licensed psychologist or midwife complete Section III.***
4. ***Mail or fax form to Fund Office (see above for information).***

For Fund Office Use Only:

Inc. _____ Date: _____

Paid from _____ Thru: _____

By: _____ Claim No: _____

When do Short-Term Disability Income Benefits start?	
For Injuries	**For Illness**
If the disability is caused by an injury, benefits will start on the first day that you receive treatment by a Physician after the date you last worked because of the injury. Please note, if the disability begins more than 90 days after the injury occurs that results in the disability, benefits will be provided under the same guidelines established for illness.	If the disability is caused by an illness, you must satisfy a waiting period before Short-Term Disability Benefits begin. The waiting period starts on the first day you receive treatment by a physician after the date you last worked because of the illness. The waiting period is 7 days (beginning with the date of the first treatment). Short-term Disability Income Benefits start on the eighth day.

When do Short-Term Disability Income Benefits end?

Short-Term Disability benefits end on the earliest of the following dates:

- the last day that you are disabled, except when you have been released to light duty by your Physician and there is no light duty available from your employer;
- the end of the maximum payment period listed in your Schedule of Benefits;
- the day that your employer ceases to be a participating employer with the Fund;
- the date you begin receiving Social Security benefits, retirement benefits from any union, union-management pension fund or any other retirement plan;
- the date of your death.

SECTION I -- TO BE COMPLETED BY PARTICIPANT

Last Name	First Name	Middle Name		SSN or UID
Home Address	City	State	Zip	Phone No.
Employer				Local Union No.

Date sickness began or injury occurred _____ Was this sickness or injury caused by employment? ☐ Yes ☐ No

Is claim due to accidental injury? ☐ Yes ☐ No If yes, state fully how and where the injury occurred _____

_____

Authorization

With my signature, I hereby authorize the release of any medical information necessary to process this claim and certify this information is true and accurate to the best of my knowledge.

_____ _____

Participant Signature Date

Teamsters Joint Council No. 83 of Virginia Health & Welfare and Pension Funds

www.tjc83funds.org
8814 Fargo Road · Suite 200 · Richmond, VA 23229
Phone (804) 282-3131 · 800-852-0806 · Fax (804) 288-3530

DISABILITY CLAIM FORM

SECTION II -- TO BE COMPLETED BY EMPLOYER

Employee's Last Name	Employee's First Name	Employee's Middle Name	SSN or UID

Employer Name	Employer Phone No.

Has claim been filed or is it possible claim will be filed for this disability under any Worker's Compensation Act or similar law? ☐ Yes ☐ No

Actual date last worked (do not include vacation/sick time, only include time actually worked): _____

Reason (please check one):

- ☐ Non-occupational illness/injury
- ☐ Occupational illness/injury
- ☐ Other (give reason)

_____ _____
Signature of Employer Representative completing form Date

_____ _____
Printed Name of Employer Representative completing form Title

SECTION III -- TO BE COMPLETED BY PHYSICAN, LICENSED PSYCHOLOGIST OR MIDWIFE

Patient's Last Name	Patient's First Name	Patient's Date of Birth

Patient's Address	City, St	Zip

Initial Treatment Date	Date of Most Recent Treatment	Diagnosis Code

Description of Treatment Plan

Diagnosis or Nature of Illness or Injury	Date of Illness (first symptoms) or Injury (accident)

If due to Injury, how?

Was condition caused by patient's employment? ☐ Yes ☐ No	Was condition caused by auto accident? ☐ Yes ☐ No

For services related to hospitalization, date of admission:	For services related to hospitalization, date of discharge:

Total Disability Start Date	Total Disability End Date	Return to Work Date

Physician or Provider's Name	Physician or Provider's Phone No.

Physician or Provider's Address	City, St	Zip

_____ _____
Physician or Provider's Signature Date