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

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DISABILITY CLAIM FORM

To file a claim:

1. ***Section I: Must be completed by participant.***
2. ***Section II: Have your employer complete.***
3. ***Section III: To be completed by Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Physicians Assistant (PA), Licensed Psychologist, Nurse Practitioner (NP) or Midwife.***
4. ***Medical records are required and subject to review.***
5. ***Mail or fax form to Fund Office (see above for information).***

For Fund Office Use Only:

Paid from ________________ Thru: _____________

SECTION I -- TO BE COMPLETED BY PARTICIPANT
For prompt review of your claim, this form must be completed in its entirety by the appropriate person indicated in each section.

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

Participant's Street Address, City, State and Zip	Participant's Phone Number

Cause of Disability: ☐ Injury ☐ Pregnancy ☐ Illness ☐ Other	Date disability began
Is your disability work related? ☐ Yes ☐ No	If yes, have you filed a Workers' Compensation claim? ☐ Yes ☐ No

Is disability related to a motor vehicle accident or is another party liable?

☐ Yes ☐ No

Nature of illness and when symptoms first appeared, or if due to an injury, describe when, where and how the injury occurred.

I realize that failure to disclose other insurance coverage information or to falsify information to the Fund is considered a fraudulent act against the Fund.

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

Participant Signature ____ Date _________________________

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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

Has employee returned to work? ☐ Yes ☐ No If yes, as of what date? _______________________

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 DOCTOR OF MEDICINE (M.D.), DOCTOR OF OSTEOPATHY (D.O.), LICENSED PSYCHOLOGIST,*** **NURSE PRACTITIONER (N.A.), PHYSICIAN ASSISTANT (P.A.)** ***OR MIDWIFE:*** *The following information is required to document the patient's inability to work. **Medical records are required and subject to review***

Provider's Name	Provider's SSN or Tax ID	Provider's Phone No.
Provider's Address	**Provider's City, St**	**Provider's Zip**
Initial Treatment Date	**Date of Most Recent Treatment**	**Diagnosis Code**

If disability is due to pregnancy, expected delivery date	If disability is due to pregnancy, actual delivery date

Description of Treatment Plan

Date of Illness (first symptoms) or Injury (accident)	Has patient ever had the same or similar symptoms? If yes, please provide details, including dates. ☐ Yes ☐ No
Was condition caused by patient's employment? ☐ Yes ☐ No	Was condition caused by auto accident? If yes, please describe and list dates ☐ 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

I certify that the information I have provided above is complete and true to the best of my knowledge.

____ _______________________________

Provider's Signature Date