

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.), Licensed Psychologist 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
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Participant's Street Address, City, State and Zip	Participant's Phone Number
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Cause of Disability: Injury Pregnancy Illness Other	Date disability began
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Is your disability work related? Yes No	If yes, have you filed a Workers' Compensation claim? Yes No
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Is disability related to a motor vehicle accident or is another party liable? Yes No
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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 _____

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 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