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

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DISMEMBERMENT BENEFIT CLAIM FORM

This form must be completed within 90 days of the date in which the Accidental Bodily Injury occurred and returned to the Fund Office using the contact information listed above.

This section must be completed by Participant.			
Your Name			Your SSN or UID
Your Mailing Address			City, St Zip
Your Email Address			Your Phone No.
Date Accident Occured	Date Last Worked	Description of How Injury Occurred	
Which Limb was Amputated?	Doctor who Performed Amputation	Date of Amputation	
Have you ever had any previous injury, disease or defect to this limb? If so, please describe. ☐ Yes ☐ No			
Your Signature			Date

This section must be completed by the Participant's treating physician.		
Your Patient's Name		Date you first treated this patient
Was the patient hospitalized? If so, provide name of hospital ☐ Yes ☐ No	Describe the injury and state which limb was injured.	
Did you perform any operation? ☐ Yes ☐ No	If so, describe operation and provide date.	
Was entire limb amputated? ☐ Yes ☐ No	Description of exact point of amputation.	
Has the patient received medical or surgical treatment at any time for any disorder, disease or previous injury affecting the amputated limb? If so, please explain. ☐ Yes ☐ No		
Was the injury described above, of itself, and independent of all other causes, sufficient to require amputation? ☐ Yes ☐ No	Did any disease or any previous injury or impairment contribute to the amputation? ☐ Yes ☐ No	
If yes, dates of treatment or diagnosis of such disease or injury		
Physician's Name		Physician's Phone No.
Physician's Address		City, State Zip
Physician's Signature		Date