



**TEAMSTERS
JOINT COUNCIL
NO. 83
OF VIRGINIA**
HEALTH &
WELFARE AND
PENSION FUNDS

SHORT-TERM DISABILITY (STD) CLAIM FORM

IMPORTANT INFORMATION & INSTRUCTIONS

- This form must be fully completed by the Employee, Employer, and Attending Physician.
- Benefits are payable only if the claimant meets the Plan's definition of disability, including being completely unable to perform each and every material duty of his or her occupation.
- The Fund may require objective medical evidence, periodic updates, and/or an Independent Medical Examination (IME).
- Incomplete or insufficient documentation will delay or result in denial of the claim.

*Submit completed
form to:*

**TJC83 H&W Fund
Attn: STD Claims
8814 Fargo Rd, Ste. 200
Richmond, VA 23229
Fax: (804) 288-3530**

SECTION 1 – EMPLOYEE STATEMENT

EMPLOYEE INFORMATION

Name: _____ SSN (last 4 digits): _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

EMPLOYMENT INFORMATION

Employer Name: _____ Job Title: _____

Last Day Worked: _____ Date Disability Began: _____

DISABILITY INFORMATION

1. Describe your illness or injury: _____

2. Are you able to perform any of your job duties? Yes No

3. Have you worked in any capacity since disability began? Yes No

If yes, explain: _____

OTHER BENEFITS / OFFSETS

Are you receiving or applying for:

Social Security Disability Yes No State Disability Benefits Yes No Other wage replacement benefits Yes No

If yes, provide details: _____

WORKERS' COMPENSATION INFORMATION

Is your condition related to a work-related injury or illness? Yes No

If yes, complete the following:

Date of injury: _____

Employer reported to: _____

Workers' Compensation claim filed? Yes No Pending

Claim number: _____

Insurance carrier: _____

Adjuster name/contact: _____

Are you receiving or eligible to receive Workers'

Compensation wage benefits? Yes No Pending

WORKERS' COMPENSATION ACKNOWLEDGMENT

I understand that:

- I must pursue any available Workers' Compensation benefits
- If Workers' Compensation is approved, no STD benefits will be payable
- The Fund may communicate directly with the Workers' Compensation carrier
- Failure to disclose Workers' Compensation information may result in denial or recovery of benefits

THIRD-PARTY LIABILITY / SUBROGATION INFORMATION

Was your illness or injury caused by the act or omission of another person or entity? Yes No

If yes, complete the following:

Date of incident: _____ Name of responsible party (if known): _____

Description of incident: _____

Insurance company (if known): _____

Are you represented by an attorney? Yes No *If yes:* Attorney name: _____

Law firm: _____ Phone/email: _____

SUBROGATION AND REIMBURSEMENT ACKNOWLEDGMENT

I understand and agree that:

- To the extent permitted under the Plan, the Fund has the right to recover (subrogate) any benefits paid if my disability is caused by a third party
- I must notify the Fund of any claim, settlement, or lawsuit related to my injury
- I agree to reimburse the Fund from any recovery obtained from a third party
- I will not take any action that would impair the Fund's recovery rights
- The Fund may communicate directly with my attorney or insurer regarding this claim

EMPLOYEE CERTIFICATION

I certify that the information provided is true and complete. I understand that eligibility for STD benefits requires that I be completely unable to perform each and every material duty of my occupation. I agree to:

- Provide objective medical evidence as requested
- Participate in an Independent Medical Examination (IME) if required
- Notify the Fund immediately of any return to work or change in condition

I understand that failure to comply may result in denial or termination of benefits.

Signature: _____

Date: _____

SECTION 2 – EMPLOYER CERTIFICATION

EMPLOYER INFORMATION

Employer Name: _____

Contact Name/Title: _____

Phone/Email: _____

EMPLOYEE INFORMATION

Employee Name: _____

Job Title: _____

Last Day Worked: _____

EMPLOYER CERTIFICATION OF DISABILITY

The undersigned Employer certifies:

1. **Material Duties** The Employer has reviewed and confirms the material duties of the Employee's position.
2. **Inability to Perform Duties** Based on available information, the Employee is completely unable to perform each and every material duty of his or her occupation as of the date above.
3. **Work Status (check one):**
 Not working in any capacity Working modified/light duty (details below) Modified duty available but declined
4. **Modified Duty Details (if applicable):** _____
5. **Ongoing Notification Requirement** Employer agrees to notify the Fund of any return to work or status change.
6. **Reliance / Accuracy** The Fund will rely on this certification. Any misrepresentation may result in denial of benefits and recovery of overpayments.

EMPLOYER WORKERS' COMPENSATION CONFIRMATION

To the best of the Employer's knowledge: Has a Workers' Compensation claim been reported? Yes No Unknown

Is the Employer contesting the claim? Yes No

Employer Authorized Representative (Printed Name): _____

Signature: _____ **Date:** _____

SECTION 3 – ATTENDING PHYSICIAN STATEMENT

MEDICAL INFORMATION

Diagnosis: _____ Date symptoms began: _____
Date unable to work: _____ Initial Treatment Date: _____ Last Treatment Date: _____

FUNCTIONAL CAPACITY

Is the patient completely unable to perform each and every material duty of their occupation? Yes No

If no, list restrictions: _____

OBJECTIVE MEDICAL EVIDENCE

Attach supporting documentation, including (as applicable):

- Clinical notes
- Diagnostic testing (MRI, X-ray, labs, etc.)
- Treatment plan

TREATMENT PLAN

Frequency of treatment: _____ Estimated return-to-work date: _____

PHYSICIAN CERTIFICATION

I certify that the above is medically supported and based on objective findings.

Physician Name (Printed): _____ Phone #: _____

Signature: _____ **Date:** _____ **TIN#:** _____

SECTION 4 – AUTHORIZATION & ACKNOWLEDGMENTS

I authorize the release of medical, employment, and benefit information necessary to evaluate this claim. I acknowledge and agree:

The Fund may require ongoing proof of disability

- Benefits may be reduced by other income (offsets) as permitted under the Plan
- The Fund may require an IME or peer review at its discretion
- Failure to cooperate may result in denial or termination

Employee Signature: _____ **Date:** _____

SECTION 5 – CONTINUING ELIGIBILITY & RECERTIFICATION

- Claimant must provide updated medical certification every 30 days
- Failure to provide updated information will result in suspension or termination of benefits

SECTION 6 – CLAIMS AND APPEALS NOTICE

If your claim is denied, in whole or in part, you will receive a written notice explaining:

- The specific reason(s) for the denial
- Reference to Plan provisions
- Any additional information required
- Your right to appeal

You (or your authorized representative) may file a written appeal within 180 days of receipt of the denial notice (or as provided under the Plan).

The Board of Trustees (or its delegate) will review your appeal in accordance with ERISA and the Plan's claims procedures.

SECTION 7 – FUND OFFICE USE ONLY

LDW: _____ Contrib Pd: _____ RTW: _____ 26 Week Max: _____ Claim Complete: Yes No
IME Required: Yes No – Approved: Yes No – WC overlap reviewed Yes No – Subrogation potential evaluated Yes No
Benefit Start Date: _____ Reviewer: _____