PROOF OF DISABILITY CLAIM FORM

TEAMSTERS MANAGED HEALTH CARE TRUST FUND

Forward Completed Form To:

P.O. Box 757 • Pleasanton, CA 94566
(925) 426-3555 • Fax (925) 426-3565

PART 1. TO BE COMPLETED BY THE EMPLOYEE

Name of Employer _____ Date Employed _____
Firm Name

1. Employee's Name (Please Print) | 2. Date of Birth | 3. Social Security Number

4. Home Address – Number and Street | City | State | Zip | 5. Telephone Number

6. Date last worked
Date _____, 20_____

7. Nature of sickness or injury

8. Are you, or have you been, on FMLA leave for this disability?
❑ Yes* ❑ No

9. If yes, the date of your FMLA leave
From Thru

10. Have you performed any work for wages during the period you are claiming disability benefits? ❑ Yes ❑ No

11. Date first treated
Date _____, 20_____

12. Have you returned to work? ❑ Yes ❑ No

13. Date of return to work
Date _____, 20_____

14. Have you filed a prior claim with this office for this disability?
❑ Yes ❑ No
When? _____

The above answers are true and complete according to the best of my knowledge and belief. I hereby authorize my attending physician, and any hospital, to furnish and disclose all facts concerning this disability.

Date _____ Local Union No. _____ Signature _____ EMPLOYEE SIGN HERE

*The Trust Fund's disability waiver policy is not applicable to participants while they are eligible for, and/or receiving, FMLA leave. However, if you remain totally disabled at the conclusion of your FMLA leave, the Trust Fund may then continue coverage for up to three (3) months in accordance with the Trust Fund's disability waiver policy. Please see your SPD for a full explanation of eligibility guidelines.

PART II. ATTENDING PHYSICIAN'S STATEMENT

1. Patient's Name and Address | 2. Age

3. Diagnosis and concurrent conditions (If diagnosis code other than ICDA* used, give name).

4. Dates of services (If previous form submitted to this plan, you need show only dates since last report.)

5. Patient was continuously totally disabled (unable to work)
From Thru

6. Patient was partially disabled
From Thru

7. If still disabled, date patient should be able to return to work

8. Patient was hospital confined
From Thru

Date | Physician's Name (print) | Signature | Degree | Telephone

Individual Practitioners – SS # | | |
All Others – Employer I.D. # | |

Must be furnished under authority of law.

Street Address | City or Town | State | Zip Code