

PROOF OF DISABILITY CLAIM FORM

Send completed form to:
 Teamsters Benefit Trust (TBT) • P.O. Box 5820 • Fremont, CA 94537-5820 • (510) 796-4676 • (800) 533-0119 • Fax (510) 795-9237

PART I — TO BE COMPLETED BY THE EMPLOYEE (Please Print)

Name of Employer (Company Name)		Date Hired (Month-Day-Year)		Local Union Number	
Employee's Name (Last, First, Middle Initial) <i>Please Print</i>			Birth Date (Month-Day-Year)		Social Security Number
Home Address (<i>Please Print</i>) <input type="checkbox"/> Check if new		City	State	Zip Code	Home Phone ()
Date Last Worked (Month-Day-Year) A.M. _____ P.M. _____		Have you performed any work for wages during the period you are claiming disability benefits? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, dates? (Month-Day-Year)		Is disability due to an accident? YES <input type="checkbox"/> NO <input type="checkbox"/> Was it work-related? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Nature of Sickness or Injury (If pregnancy, due date)					
Date First Treated (Month-Day-Year)		Have you returned to work? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, date? (Month-Day-Year)		Please advise if light duty is available YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, dates worked? (Month-Day-Year)	
Date of Return to Work (Month-Day-Year)		Have you filed a prior claim with this office for this disability? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, date? (Month-Day-Year)			

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

Employee's Signature	Date Signed (Month-Day-Year)
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PART II — ATTENDING PHYSICIAN'S STATEMENT (Please Print)

Patient's Name and Address			
ICD-10 Diagnostic Code and description (Must provide clear and accurate ICD-10 code. If pregnancy, give E.D.C.)			
Dates of Services (If previous form submitted to this plan, you only need to show dates since last report)			
Patient was continuously totally disabled (unable to return to work) From: _____ To: _____ (Month-Day-Year) (Month-Day-Year)		Patient was partially disabled From: _____ To: _____ (Month-Day-Year) (Month-Day-Year)	
If still disabled, date patient should be able to return to work (Month-Day-Year)		Patient was hospital confined From: _____ To: _____ (Month-Day-Year) (Month-Day-Year)	
Date (Month-Day-Year)	Physician's Name and Degree (print) (MD or DO required)	Signature	Telephone ()
Individual Practitioner's Social Security Number		All Others—Employer NPI/TAX ID Number (Required by law)	
Street Address		City	State Zip Code