PARTICIPANT'S REPORT OF DISABILITY

Return this form to:

Michigan Conference of
Teamsters Welfare Fund
2700 Trumbull
Detroit, MI 48216
www.mctwf.org

Participant Information

Contract Number	Full Name		Date of Birth
Street Address	City-State	Zip Code	Area Code & Phone No.
Local	Present Employer (Company) Name		

For Disability Resulting from Injury - Statement of Injury

Was Injury: ☐ Work Related ☐ Auto Related ☐ Other Accident	Date of Injury
	Time of Injury
How and Where Injury Occurred (please give accurate details)	

Physician's Statement

Patient's Name _____ has been under my care from _____ to _____
and is able to return to work on _____.

Physician's Name _____ Physician's Signature _____

Employer's Statement

1. On what date did claimant last work before disabling injury or illness? _____ (Date) _____ (Hour) a.m. p.m.
2. Was claimant an actively working employee at the time he/she became disabled? ☐ Yes ☐ No
3. Is claimant still off work because of disability? ☐ Yes ☐ No
4. If claimant is working, when did the claimant first resume work? _____ (Date) _____ (Hour) a.m. p.m.
5. If claimant can be released for light duty assignments, is there work available? ☐ Yes ☐ No

Date _____ Signature _____
(Employer's Signature)

_____ _____
Phone Number (Print Name and Title)

INSTRUCTIONS TO THE CLAIMANT

1. Every item must be completed in full by yourself, your doctor, and your employer.

2. Claims cannot be considered unless these instructions are **strictly complied with**.

3. Pay careful attention to details in completing the injury portion of your claim.

4. Weekly Accident & Sickness Benefits can only be paid if the disability is supported by medical evidence. The medical evidence has to be recorded by a licensed physician and it must show that you have been under his/her personal and regular care throughout the disability period. Regular care is important to the benefit plan because it is inconceivable that a person disabled, either as a result of sickness or accidental injury to the extent that he is unable to work, does not require reasonable medical attention from a physician. Personal care does not include telephone instructions but means actually being seen by your physician, either at his office, the hospital, or your home. **Do not jeopardize your claim**. MCTWF may question or even deny Weekly Accident and Sickness benefits if you do not see your physician on a regular basis.

5. Payment will not be made to you on an automatic basis, but will be calculated based upon the information that your physician and employer furnish on the forms provided. Benefits will not be paid beyond the date your employer signs this form.

6. If your loss is due to an injury, you will be paid a benefit from the first day of the proven disability (first day following medical attention after the last day worked). If a sickness is the cause of your absence from work, the loss period will, for benefit purposes, begin on the eighth day of the proven illness (eighth day following medical attention after the last day worked).

********** **IMPORTANT** **********

This Form must be completed before benefits will be issued. You, your physician, and employer are responsible for ensuring that this form is returned properly completed. It goes without saying that the sooner MCTWF receives this form, the faster you will receive your disability payment.

Notice to Employer

The completion of this form by the Employer is not an admission of liability for Worker's Disability Compensation. This form is used exclusively for verification of the dates the claimant (employee) was actively working.

The Participant's Contract No. MUST appear on all Claims, Replicas, Inquiries and Correspondence

PHYSICIAN'S STATEMENT OF DISABILITY

Return this form to:
Michigan Conference of
Teamsters Welfare Fund
2700 Trumbull
Detroit, MI 48216
www.mctwf.org

1. Patient's Name _____ Contract No. _____
2. Diagnosis or nature of patient's illness or injury (describe complications, if any) _____

   _____

   a. ICD-9 for the disability _____
   b. Description of disability _____
3. If disability is caused by, or related to, pregnancy, please give estimated date of delivery _____
4. Date of **FIRST** treatment after last day worked _____
5. List all dates of medical attention since the first date of treatment or since the last claim was filed _____

   _____
6. Is this person under your professional care at present? ☐ Yes ☐ No Date released _____
7. Did this illness or injury arise out of patient's employment? ☐ Yes ☐ No If "Yes", explain _____

   _____
8. Did this disability require hospitalization? ☐ Yes ☐ No If "Yes", name of hospital _____
9. Period of in-patient confinement was from _____ Discharged _____
10. Describe any surgical or obstetrical procedure _____

    _____ Date performed _____
11. Please explain how your patient's illness/injury impairs his/her ability to perform their specific work activity _____

    _____
12. This patient has been continuously disabled
    (unable to perform all duties of his/her occupation) From _____ Through _____
13. If still disabled, when should the patient be able to return to work? _____
14. Describe work restrictions, if any _____

Name and Address of Physician	Tax Identification No.
	Telephone No.
	☐ MD ☐ DO ☐ DDS
	Other Degree:

Please Submit Itemized Bill for Services Rendered on Separate Medical Claim Form

Remarks or Additional Information

Signature of Physician _____ Date _____

Authorization Section

I authorize any physician, practitioner, pharmacist or other person, any hospital, including veterans administration or governmental hospital, any medical service organization, any healthcare carrier or any other institution or organization to release any information for the determination of benefits only. A photocopy of this authorization shall be as valid as the original.

Participant's Signature _____ Date _____

Know Your Disability Benefits

Under most benefit Plans, MCTWF provides participants with various types of disability benefits when they become disabled and are unable to work (see your Summary Plan Description and Schedule of Benefits for those available to you). To better help you to understand your disability benefits, we have summarized your options below. If you remain uncertain regarding you benefit entitlements, we urge you to contact MCTWF's Customer Communications Department to discuss your individual circumstance.

- **Weekly Accident & Sickness Benefit** (applies to participant only) - If you are disabled due to a non-occupational or non-excluded auto related accident or sickness while you are actively employed and are unable to perform the regular duties of your employment, you may qualify to receive the Weekly Accident & Sickness Benefit. You will receive the weekly benefit amount and the maximum weeks available as indicated in your Schedule of Benefits. During the period you are receiving this benefit, you and your eligible dependents will remain eligible for all other plan benefits. Any remaining benefit bank weeks you have available will be applied once your Weekly Accident and Sickness benefit has been exhausted. You must file for this benefit within fifteen months after the non-occupational or non-excluded auto related accident or sickness occurs.

- **Extended Disability** (also applies to eligible dependents) - If you are eligible for disability benefits under your MCTWF plan and your coverage has ended, benefits for services rendered in connection with the disability may be extended for up to the earlier of 24 months or your eligibility for Medicare benefits. For the first 90 days of such extension, benefit levels are dictated by whether you have chosen a network or out-of-network provider (subject to any deductible, copayment or coinsurance amount required under your MCTWF plan). For the last 21 months of such extension, coverage is provided at the out-of-network payment levels regardless of whether you have chosen a network or out-of-network provider. Coverage is limited to the treatment received for the continuing disability.

- **Total and Permanent Disability Benefit** (applies to participant only) If you have a disability that is expected to continue for the remainder of your life and that causes you to be unable to engage in any regular employment or occupation for compensation, profit or gain for which you may be suited by your education, training or experience, you may be qualified to apply for Total and Permanent Disability Benefits. This benefit pays a monthly amount directly to you for a predetermined length of time but does not provide medical care or hospitalization coverage. In order to be considered for the Total and Permanent Disability benefit, you are required to fill out an application form. You may obtain application forms from MCTWF's website at www.mctwf.org or by contacting MCTWF's Customer Communications Department at 313-964-2400. All claims must be filed within fifteen months after the end of your active coverage under the Plan. Applications will be denied if they are received after the fifteen month period. While collecting the Total and Permanent Disability Benefit, you may also be eligible for the Extension of Basic Benefits or the Extension of Extended Benefits listed above.

If you are retiring because of a disability, you should contact MCTWF's Customer Communications Department immediately so that we may help you to determine which benefit options would be in your best interest to select.