





## 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. Loss of Time (Weekly Accident & Sickness Benefits) can only be paid if the loss is supported by medical evidence. The medical evidence has to be recorded by a qualified healthcare provider 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 doctor. Personal care does not include telephone instructions but means actually being seen by your doctor, either at his office, the hospital, or your home. **Do not jeopardize your claim.** The benefit plan may question or even deny the Loss of Time Benefit if your doctor does not see you regularly.
5. Your payment will not be made to you on an automatic basis, but it will be calculated upon the information that your physician and employer furnish on the forms provided. Benefits may 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 of medical attention after the last day worked). If an illness 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 healthcare provider, 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?
7. Did this illness or injury arise out of patient's employment?
8. Did this disability require hospitalization?
9. Period of in-patient confinement was from Discharged
10. Describe any surgical or obstetrical procedure
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 Healthcare Provider, 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 your benefit entitlements, we urge you to contact MCTWF's Customer Service 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.

- **Extension of Basic Benefits** (applies to participant or eligible dependent) - If you or your eligible dependent have a disability that began while covered by an MCTWF Plan your Basic Benefit may continue beyond the termination of your coverage and you may qualify to have basic medical and hospital benefits extended for up to 90 days at no cost. This is limited to the treatment received for the continuing disability only and benefits are applied the same as if you were actively working. You are responsible for providing MCTWF with documentation validating that disability. Documentation from your physician validating the disability must be filed within one year from the date your active coverage ceases.

- **Extension of Extended Benefits** (applies to participant or eligible dependent) - If you or your eligible dependent have a disability that began while covered by an MCTWF Plan your Extended Benefit may continue beyond the termination of your coverage and you may qualify to have your Extended Benefits extended for up to two years at no cost. This coverage is limited to the treatment received for the continuing disability only and benefits are paid at the out-of-network benefit level listed in your Schedule of Benefits. You are responsible for providing MCTWF with documentation validating that disability. Documentation from your physician validating the disability must be filed within one year from the date your active coverage ceases.

- **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](http://www.mctwf.org) or by contacting MCTWF's Customer Service 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 Service Department immediately so that we may help you to determine which benefit options would be in your best interests to select.