Michigan Conference of Teamsters Welfare Fund
2700 Trumbull Avenue, Detroit, Michigan, 48216 ▪ (313) 964-2400 ▪ www.mctwf.org

Accidental Death and Dismemberment

Participant Information

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

This is a Claim for:

- ☐ Accidental Death (please attach a certified copy of the death certificate)
- ☐ Accidental Dismemberment

Date of Accidental Injury	Date of Death/Dismemberment
Place of Death/Dismemberment	
Describe fully how the Accidental Injury occurred, the nature of injuries received, and loss(es) for which claim is made	
Participant's or Representative's Signature	Date

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

This Form must be completed before benefits will be issued. You and your healthcare provider 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 benefit payment.

Physician's Statement for Dismemberment Claim on reverse side

Physician's Name and Degree				
Physician Address	City		State	Zip Code
Patient's Name	Date of Birth	Date Accidental Injury Occurred	Date Patient First Consulted you for this Condition	

Nature of Injury (describe complications, if any)

Did the Accidental Injury Result in the Loss of:

Hands: ☐ Right ☐ Left ☐ Both	Was dismemberment at or above wrist joint? ☐ Yes ☐ No	Date of Dismemberment	Extent of Dismemberment
Feet: ☐ Right ☐ Left ☐ Both	Was dismemberment at or above ankle joint? ☐ Yes ☐ No	Date of Dismemberment	Extent of Dismemberment

Total and Irrecoverable Loss of Sight of:

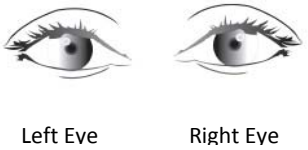
Right Eye ☐ Yes ☐ No Date of Loss _____ Was Eye Removed? ☐ Yes ☐ No Date Removed_____

Left Eye ☐ Yes ☐ No Date of Loss _____ Was Eye Removed? ☐ Yes ☐ No Date Removed_____

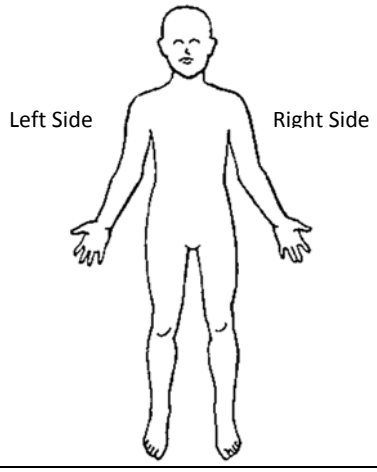
In your opinion, was any disease, infection, bodily or mental infirmity an underlying cause in the loss(es) indicated above? ☐ Yes ☐ No

In your opinion, did the loss(es) result from the voluntary or involuntary use of drugs or alcohol, any self-inflicted injury, or attempted self-destruction? ☐ Yes ☐ No

To the right mark the eye (s) in which loss of sight occurred or the area in which hand or foot dismemberment occurred.



Left Eye Right Eye



Is patient still under your care for this condition? ☐ Yes ☐ No

If discharged, give date of discharge _____

Physician's Signature	Date