# COVID-19 WEEKLY ACCIDENT & SICKNESS BENEFITS CLAIM FORM

If you have questions regarding this form, please contact the MCTWF Call Center at 800-572-7687

Mail this form to:
Michigan Conference of Teamsters Welfare Fund
2700 Trumbull Avenue
Detroit, MI 48216

FAX Submission:
313-496-2933
EMAIL Submission
gf@mctwf.org

## Participant Information

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

**For Disability Resulting from COVID-19 ONLY**

**(Please note: Every requested item in this claim form must be completed in full by you and your doctor.)**

## PARTICIPANT'S STATEMENT OF DISABILITY

1. Are you filing this claim because you are or were unable to work due to COVID-19? _______________
   If NO, you are not eligible for COVID-19 related Weekly Accident & Sickness Benefits.
   If YES, state your last date worked prior to this disability: ________________________________________

2. Are you or were you self-quarantined? ________________________________________________________
   If YES, state the name of the health care provider who advised you to self-quarantine: _______________
   ______________________________________________________ and state the time period of the advised self-quarantine: from________ to ________ (not to exceed 14 days from date of exposure to COVID-19)

3. Are you or were you hospitalized? _________ If YES, state the name of the hospital:_______________
   _____________________________________________________and state the period of your confinement: from_______________ to ______________

4. Are you or were you receiving compensation from your Employer while off due to this disability? ______
   If YES, for what time period(s) are you or were you receiving pay (please be specific): _______________
   _____________________________________________________________________________________

5. Are you (or were you during the period of your disability) physically able to work at your place of residence (telework) if such work was offered to you by your employer? ___________________________

6. During the period of your disability, has your Employer offered you the opportunity to work remotely from your place of residence (telework)? ______________________________ If so, are you or did you telework?______ If you are or did telework, state the dates that you did so:________________________

7. If during the period of your disability, your Employer offered you the opportunity to telework, but you did not do so, please explain why you did not do so________________________________________________

## Participant Authorization -

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 ________________

PLEASE NOTE: If you are filing this form because you were self-quarantined as stated in Question 2 above, and if you are eligible for weekly accident & sickness benefits, your entitlement will cease effective as of the earlier of the end of the self-quarantine period or 14 days from your date of exposure to COVID-19. If, however, during or after the self-quarantine period, you have been determined to be infected with COVID-19, you must submit a new *COVID-19 Weekly Accident & Sickness Benefits Claim Form* to be eligible for additional benefits.

# PHYSICIAN'S STATEMENT OF DISABILITY DUE TO COVID-19

1. Patient's Name ____________________________ Contract No. ____________________________
2. COVID-19 exposure on what date: __________ How did exposure occur: ____________________________
3. Was COVID-19 Test given: ___________ If YES, what date: ________________________________
4. Date of **FIRST** treatment after last day worked: ________________________________________
5. List all dates of medical attention since the first date of treatment:____________________________________
   ____________________________________________________________________________
6. Is this person under your professional care at present? □ YES □ NO Date released:______________________
7. Did this disability require hospitalization? □ YES □ NO
8. Period of in-patient confinement was from_______________Discharged ___________________________.
9. Does the patient's physical condition prevent him/her from teleworking? ____________________________
10. Has patient been advised to self-quarantine? _____If YES, start and end date of quarantine: __________________
11. What is the reason for quarantine:________________________________________________________
12. When should the patient be able to return to work?_____________________________________________
13. Describe work restrictions, if any ____________________________________________________

| Name and Address of Physician or Health Agency | Tax Identification No. |
|---|---|
| | Telephone No. |
| | □ MD □ DO Other: ________________ |

**<u>Please Submit Itemized Bill for Services Rendered on Separate Medical Claim Form</u>**

Remarks or Additional Information:

________________________________________________________________________________

Physician Signature: Date:

## INSTRUCTIONS TO THE CLAIMANT

1. Every item must be completed in full by you and your doctor.
2. Benefits cannot be considered unless these instructions are **strictly complied with**.
3. Pay careful attention to details in completing your claim.

**IMPORTANT**

This Form must be completed before benefits will be provided. You and your Physician 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.

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

## Know Your Disability Benefits

Under most benefit Plans, MCTWF provides participants with various types of disability benefits when they become 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 Member Services Call Center to discuss your individual circumstance.

- **Weekly Accident & Sickness Benefit** (applies to participant only) - If you are disabled due to a non-occupational accidental injury, illness, or sickness due to pregnancy 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-auto related accidental injury or sickness due to pregnancy occurs.

- **Extended Disability -** If you are eligible for medical 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.