Michigan Conference of Teamsters Welfare Fund

2700 Trumbull Avenue, Detroit, Michigan, 48216 ▪ (313) 964-2400 ▪ www.mctwf.org

Total Disability Certification

Participant's Statement

This statement must be completed in its entirety by the participant or his duly appointed guardian or committee.

Participant Name	Participant Social Security Number	Date of Birth (mm/dd/yy)
	__ __ __ __ __ __ __ __ __	__ __/__ __/__ __

Street Address	City	State	Zip Code

By signing this form I certify that I have remained totally disabled as of the date of my signature.

_____ _____

Participant Signature Date

The foregoing document was signed before me this _____ day of _____ 20_____.

_____

Notary Public

My Commission Expires: _____

Physician's Statement

This statement must be completed in its entirety by the participant's treating physician.

By signing this form, I certify that the above named participant is totally disabled as of the date of my signature.

Physician's Signature: _____Date:_____

Physician Name (Please Print): _____

Title: _____

_____

Address

_____

City State Zip Code