Michigan Conference of Teamsters Welfare Fund

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

Total and Permanent Disability Benefit

Participant's Statement

This statement must be completely answered by the participant or his duly appointed guardian or committee.

1. Participant Name	2. Participant Contract Number __ __ __ __ __ __ __ __ __	3. Date of Birth (mm/dd/yy) __ __/__ __/__ __
3. Describe fully participant's present condition.	4. To what extent is the participant unable to work in any occupation?	
5. Give date of injury or beginning of illness causing present condition. __ __/__ __/__ __ (mm/dd/yy)	6. When was participant compelled to give up part of his duties? __ __/__ __/__ __ (mm/dd/yy)	
7. When was participant compelled to give up all his duties)? __ __/__ __/__ __ (mm/dd/yy)	8. How does participant spend his time?	
9. Has participant been employed in any other capacity since commencement of disability? If so, give particulars.	10. When does participant expect to return to work? __ __/__ __/__ __ (mm/dd/yy)	

11. Give name and address of every physician who attended to participant during present illness or injury (use separate sheet if necessary).

Duration (mm/yy)	Name of physician	Address of physician
From __ __/__ __ To __ __/__ __	_____	_____
From __ __/__ __ To __ __/__ __	_____	_____
From __ __/__ __ To __ __/__ __	_____	_____

12. What illness or injury has participant required the services of a physician *prior* to present illness or injury?

State illness or injury	Duration (mm/yy)	Name of physician	Address of physician
_____	From __ __/__ __ To __ __/__ __	_____	_____
_____	From __ __/__ __ To __ __/__ __	_____	_____
_____	From __ __/__ __ To __ __/__ __	_____	_____

13. Is there a family history of this illness? If so, give particulars.

14. What other life, government, health or accident benefits are being provided for this disability?

Name of Company	Address	Amount of weekly or monthly benefit
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby authorize any of the above stated physicians to disclose any or all of my protected health information to the Michigan Conference of Teamsters Welfare Fund. I understand that upon approval by MCTWF of this application for Total and Permanent Disability benefits, any right that I may have to participate in the MCTWF Retirees Plan are forfeited.

Sworn to before me this _____day of _____ 20 ___

_____
Notary Public

Participant Signature _____

Address _____

_____

(over)

Are you currently collecting a pension? Yes ☐ No ☐

If yes, from what Pension Fund? _____

Have you opted for pension deferral? Yes ☐ No ☐

If yes, from what Pension Fund? _____

Effective Date _____

Employment History

Please list your previous employers and the time period you were employed with each company below:

Employer Name	From (mm/dd/yy)	To (mm/dd/yy)
	__ __/__ __	__ __/__ __
	__ __/__ __	__ __/__ __
	__ __/__ __	__ __/__ __
	__ __/__ __	__ __/__ __
	__ __/__ __	__ __/__ __
	__ __/__ __	__ __/__ __
	__ __/__ __	__ __/__ __
	__ __/__ __	__ __/__ __
	__ __/__ __	__ __/__ __

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Attending Physician's Statement

Participant's Name	Participant Contract Number __ __ __ __ __ __ __ __ __	Date of Birth (mm/dd/yy) __ __/__ __/__ __
Address	City	State / Zip Code

1. **History** a. When did present illness begin and what were the symptoms at the time? ..... b. Is there a history of an illness of the same nature, or pertinent to the present disability? c. When was the participant required to cease work?	_____ _____ __ __ / __ __ / __ __ (mm/dd/yy)
2. **Present Condition** a. Subjective symptoms ..... b. Objective findings ..... *The results of x-rays, E.K.Gs., or any other special studies, will be appreciated.*	_____ _____
3. **Diagnosis** What is the diagnosis?.....	
4. Treatment a. First visit ..... Last visit ..... Frequency of Visits? ..... b. When did you last examine the patient?..... c. Is participant ambulatory?..... Is Participant confined to	 __ __ / __ __ / __ __ (mm/dd/yy) __ __ / __ __ / __ __ (mm/dd/yy) ☐ Daily ☐ Weekly ☐ Monthly __ __ / __ __ / __ __ (mm/dd/yy) ☐ Yes ☐ No ☐ Bed ☐ House ☐ Hospital
5. **Progress**	☐ Improved ☐ Unimproved ☐ Retrogressed
6. **Degree of Disability** a. Has the participant been able to do any work? If so, from what date? ..... b. If not, when do you think he will be able to work? ..... c. If Indefinite or Never, on what date did he become totally or permanently disabled?	Regular Work / Other Work __ __ /__ __/__ __ (mm/dd/yy) / __ __ /__ __/__ __ (mm/dd/yy) Approximate date __ __ /__ __/__ __ (mm/dd/yy) ☐ Indefinite ☐ Never Approximate date __/__/__ (mm/dd/yy)
7. If disability involves a mental condition, is the participant competent to endorse checks and direct the use of the proceeds thereof with a clear understanding of the nature of his acts?	☐ Yes ☐ No

(over)

8. Complete the appropriate section if the disability is due to a cardiac condition, pulmonary tuberculosis, or visual impairment.

a. **Cardiac**	
(1) Functional Capacity (AHA):.....	☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)
(2) Blood Pressure	_____
b. **Pulmonary Tuberculosis**	
(1) Extent:	☐ Minimal ☐ Moderately Advanced ☐ Far Advanced
(2) Clinical (NTA):	☐ Active ☐ Arrested ☐ Inactive
(3) Exercise Status:.....	☐ Not Ambulatory ☐ Partially Ambulatory ☐ Living Under Ordinary Conditions of Life
(4) Any Adverse Laboratory Findings?.....	_____
Sputum Last Positive?	__ __ /__ __/__ __ (mm/dd/yy)
(5) Therapy:.....	Type & Dates: _____
c. Visual Impairment	
(1) Is participant totally blind?	☐ Yes ☐ No
(2) If not totally blind, what was vision at last observation?	(*Snellen Notation*) With Glasses: O.D._____ O.S. _____ Date __ __ /__ __/__ __
(3) What is the extent of any gross visual field defect?.....	Without Glasses: O.D._____ O.S. _____ Date __ __ /__ __/__ __
(4) Can vision be improved by:.....	☐ Treatment ☐ Operation ☐ Lenses

9. Remarks

Signature: _____Date:_____

Title: _____

_____
Address

_____
City State Zip Code

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Employer's Statement

This statement must be completed by the Employer, or his duly authorized agent, as a Superintendent, Paymaster, etc. It must not be completed by a Clerk, Bookkeeper or Foreman, unless specially authorized.

1. Full name of Participant and Contract Number

2. Name and business address of Participant's employer.

3. Nature of business.

4. What was exact nature of work performed by Participant prior to his present condition?

5. When did Participant enter your employ?

(Month) (Day) (Year)

6. (a) When was Participant compelled to give up part of his duties? (Give exact date)

(Month) (Day) (Year)

(b) When was Participant compelled to give up all of his duties? (Give exact date)

(Month) (Day) (Year)

7. Is Participant's illness or injury the sole cause of his absence from duty? If not, give particulars.

8. Has Participant been absent from work before because of any illness or injury? If so, give particulars.

9. (a) Is Participant still in your employ?

(b) If so, when do you expect him to return to work?

Signature _____

Witness _____ Official Position _____

Dated _____ Dated _____

(Month) (Day) (Year) (Month) (Day) (Year)

NOTICE

Upon approval by MCTWF of this application for Total and Permanent Disability (TPD) benefits, all rights to participate in the MCTWF Retirees Plan are forfeited. In furnishing this application blank, the Michigan Conference of Teamsters Welfare Fund (MCTWF) does not thereby admit that there are any benefits covering the person claiming to be disabled; and MCTWF expressly reserves all its rights and defenses.

There is no need to employ any person to help collect any sums rightly due under the TPD Benefit of MCTWF nor need any one incur any expense for this purpose except to pay the customary charges or fees required to complete the several forms or statements set forth in the following instructions.

The statements are to be furnished without expense to MCTWF. The statements usually required are as follows:

Participant's Statement: To be made by the Participant under the TPD Benefit. If the Participant is a minor, a statement may be required from such minor's guardian. If the Participant is incompetent the statement is to be made by the Participant's Guardian or Trustee, with changes assumed to be made in the question such as to apply to the Participant; a certified copy of the appointment and authority of such Guardian or Trustee must be furnished.

Attending Physician's Statement: To be made by each physician who attended the Participant in connection with the illness or disability for which the Participant is making claim. For this purpose MCTWF will furnish as many forms of the Attending Physician's Statement as are needed.

Employer's Statement: To be made by Participant's Employer. If the Participant was employed by an association, company, corporation, etc., this statement should be made by an officer of such concern; preferably by the officer under whom the Participant was employed.

The statements should be sworn to before officers authorized by law to administer oaths. If sworn to before an office not using an official seal, his authority and the genuineness of his signature must be attested by the proper Clerk under the seal of his office.

Every question should be distinctly and fully answered.

MCTWF reserves the right to obtain further information should it be deemed necessary.