



## PARTICIPANT'S REPORT OF DISABILITY

Return this form to:

Michigan Conference of  
Teamsters Welfare Fund  
2700 Trumbull  
Detroit, MI 48216  
www.mctwf.org

### Participant Information

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

### For Disability Resulting from Injury - Statement of Injury

Was Injury: <input type="checkbox"/> Work Related <input type="checkbox"/> Auto Related <input type="checkbox"/> Other Accident	Date of Injury  <hr/> Time of Injury
How and Where Injury Occurred (please give accurate details)	

### Physician's Statement

Patient's Name \_\_\_\_\_ has been under my care from \_\_\_\_\_ to \_\_\_\_\_  
and is able to return to work on \_\_\_\_\_.

Physician's Name \_\_\_\_\_ Physician's Signature \_\_\_\_\_

### Employer's Statement

1. On what date did claimant last work before disabling injury or illness? \_\_\_\_\_ a.m.  

Date
Hour

p.m.
2. Was claimant an actively working employee at the time he/she became disabled?  Yes  No
3. Is claimant still off work because of disability?  Yes  No
4. If claimant is working, when did the claimant first resume work? \_\_\_\_\_ a.m.  

Date
Hour

p.m.
5. If claimant can be released for light duty assignments, is there work available?  Yes  No

Date \_\_\_\_\_ Signature \_\_\_\_\_  
(Employer's Signature)

\_\_\_\_\_ (Print Name and Title)  
Phone Number



## INSTRUCTIONS TO THE CLAIMANT

1. Every item must be completed in full by yourself, your doctor, and your employer.
2. Benefits 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. Benefits can only be paid if the disability is supported by medical evidence. The medical evidence has to be recorded by a licensed physician 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 physician. Personal care does not include telephone instructions but means actually being seen by your physician, either at his office, the hospital, or your home. **Do not jeopardize your claim for benefits.** MCTWF may question or even deny benefits if you do not see your physician on a regular basis.
5. Benefits will not be provided to you on an automatic basis, but will be calculated based upon the information that your physician and employer furnish on the forms provided. Benefits will not be provided beyond the date your employer signs this form.
6. If your plan provides for disability income benefits and your loss is due to an injury, you will be provided benefits from the first day of the proven disability (first day following medical attention after the last day worked). If your loss is due to a sickness, 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 provided. You, your physician, 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 benefit.

**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.mctwff.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 Physician 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.

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 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 and non-auto related accidental injury or sickness or illness 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 or illness due to pregnancy occurs.
- **Extended Disability** (also applies to eligible dependents) - If you are eligible for disability 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.
- **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 Member Services Call Center 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 Member Services Call Center immediately so that we may help you to determine which benefit options would be in your best interest to select.