



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

Accidental Death and Dismemberment

Participant Information

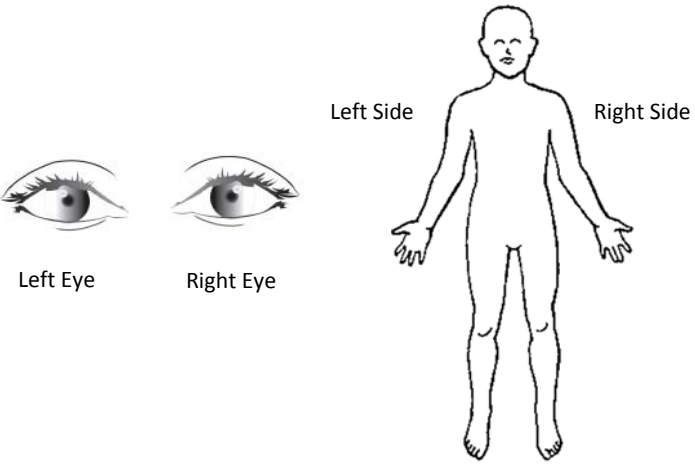
Contract Number	Full Name	Date of Birth	
Street Address	City-State	Zip Code	Area Code & Phone No.
Local	Present Employer (Company) Name		

<u>This is a Claim for:</u>	
<input type="checkbox"/> Accidental Death (please attach a certified copy of the death certificate) <input type="checkbox"/> 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: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	Was dismemberment at or above wrist joint? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Dismemberment	Extent of Dismemberment
Feet: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	Was dismemberment at or above ankle joint? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Dismemberment	Extent of Dismemberment
Total and Irrecoverable Loss of Sight of: Right Eye <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Loss _____ Was Eye Removed? <input type="checkbox"/> Yes <input type="checkbox"/> No Date Removed _____ Left Eye <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Loss _____ Was Eye Removed? <input type="checkbox"/> Yes <input type="checkbox"/> No Date Removed _____			
<u><i>In your opinion, was any disease, infection, bodily or mental infirmity an underlying cause in the loss(es) indicated above? <input type="checkbox"/> Yes <input type="checkbox"/> No</i></u>			
<u><i>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</i></u>			
To the right mark the eye (s) in which loss of sight occurred or the area in which hand or foot dismemberment occurred.			
			
Is patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If discharged, give date of discharge			
Physician's Signature		Date	