



Return this form to:
 Michigan Conference of
 Teamsters Welfare Fund
 2700 Trumbull Avenue
 Detroit, MI 48216
 313-964-2400 www.mctwf.org

CLAIMANT'S REPORT OF DISABILITY MCTWF EXTENDED DISABILITY BENEFIT

Participant/Claimant Information

Participant Contract Number	Participant Full Name	Date of Birth	
Street Address	City-State	Zip Code	Area Code & Phone No.
Local Union	Present Employer (Company) Name		
Claimant's Full Name and address, if different from Participant			
If Claimant has other medical coverage, please state the name of the plan or the insurance carrier:			
Participant's Signature		Date	

For Disability Resulting from Accidental Injury* - Statement of Accidental Injury

Date of Accidental Injury _____

How and Where Accidental Injury Occurred (please give accurate details) _____

* An "Accidental Injury" is defined as "any disabling disorder of the body or mind that is the direct result of an occurrence that is not a sickness."

Physician's Statement

1. Patient's Name _____ has been under my care from _____ to _____ and is able to return to work on _____
2. Diagnosis or nature of member's sickness** or accidental injury (describe complications, if any)

3. Is this person totally disabled and under your professional care at present? Yes _____ No _____ Date released: _____
4. Please explain how your patient's sickness or accidental injury impairs his/her ability to work: _____

5. This patient has been continuously disabled from (date) _____ through (date) _____

Physician Signature & Date _____

Physician Name _____ MD _____ DO _____ DPM _____

Physician Address _____ City _____ State _____ ZIP _____

Physician Phone Number _____ Physician Tax ID # _____

** A "Sickness" is defined as "any disabling disorder of the body or mind (other than an Accidental Injury as above defined) and pregnancy (including abortion, miscarriage, or childbirth)."



INSTRUCTIONS TO THE CLAIMANT EXTENDED DISABILITY BENEFIT

1. Every item must be completed in full.
2. 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. Personal care does not include telephone instructions, but means actually being seen and attended to by your physician. **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.

***** **IMPORTANT** *****

This Form must be completed before Extended Disability Benefits will be provided. You and your physician are responsible for ensuring that this form is returned properly completed.

The Participant's Contract Number MUST appear on all Claims, Replicas, Inquiries and Correspondence