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_____.

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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