CLAIMANT'S REPORT OF DISABILITY
MCTWF EXTENDED DISABILITY BENEFIT

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

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. D**o 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