

Teamsters Joint Council No. 83 of Virginia

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Health & Welfare and Pension Funds

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Disability Claim Form

To file a claim:

1. Complete Section I (to be completed by you).
2. Have your Employer complete Section II.
3. Have your physician or surgeon complete Section III.
4. Mail, fax or email form to Fund Office (see above for information).

For Fund Office Use Only

Inc. _____ Date: _____
Pd from _____ through _____
By: _____ Claim # _____
Follow up sent **YES** **NO**

SECTION I – MEMBER’S STATEMENT

1. Print Your Name _____ SSN/UID# _____
2. Address _____ City _____ State _____ Zip _____
Phone No. _____
3. Your Employer’s Company Name _____ Local Union No. _____
4. Employer’s address _____ City _____ State _____ Zip _____

Complete regarding patient:

5. Date sickness began or injury occurred _____ Was this sickness or injury caused by employment? _____
6. Is claim due to accidental injury? _____ If yes, state fully how and where the injury occurred _____

Authorization

With my signature, I hereby authorize the release of any medical information necessary to process this claim and certify this information is true and accurate to the best of my knowledge.

Signed _____ Date _____

SECTION II -- EMPLOYER’S STATEMENT

Employee’s full name _____ Soc. Sec. No./UID# _____
Has claim been filed or is it possible claim will be filed for this disability under any Worker’s Compensation Act or similar law? _____

Actual date last worked: _____ Name of company _____
Reason: _____ Non-occupational illness/injury Address _____
_____ Occupational illness/injury City _____ State _____ Zip _____
_____ Other (give reason) Phone No. _____

Actual date returned to work: _____ Signed _____ Date _____
Remarks: _____ Title _____

Disability Claim Form

SECTION III – Physician, Surgeon or Other Provider

To be completed by one of the above only

1. Patient's Name _____

2. Patient's Date of Birth _____

3. Patient's Address _____ City _____ State _____ Zip _____

4. Initial treatment date _____ Date of most recent treatment _____ Diagnosis Code _____

5. Diagnosis or nature of illness or injury _____

6. Date of illness (first symptoms) or injury (accident) _____

7. If due to injury, how? _____

8. Was condition caused by: Patient's employment? Yes _____ No _____

Auto accident Yes _____ No _____

9. For services related to hospitalization, give service dates. Date of Admission _____

Date of Discharge _____

10. Dates of total disability (from) _____ (through) _____

11. Date patient able to return to work _____

12. Physician's or Provider's Name _____

Address _____

Telephone No. _____

Signature of Physician or Provider _____ Date _____