

# Teamsters Joint Council No. 83 of Virginia Health & Welfare and Pension Funds



Administered by West End Administrators, Inc.  
8814 Fargo Road · Suite 200 · Richmond, VA 23229  
Phone (804) 282-3131 · 800-852-0806 · Fax (804) 288-3530

## 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 \_\_\_\_\_

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### 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 \_\_\_\_\_