WEEKLY ACCIDENT & SICKNESS CLAIM FORM
Mail Claim to:

TEAMSTERS' HEALTH SERVICES & INSURANCE PLAN, LOCAL
Tel:

This form is an application for weekly **A & S** benefits for eligible members who are currently employed. These benefits are only payable for loss of income that is not work related. **NO** benefits are paid for the first 7 days for any accident or illness. It is not necessary for all information to be submitted on the same copy of this form.

It is **NOT NECESSARY** to be confined to your home to receive benefits, BUT **YOU MUST** be under the care of a Physician (M.D.) Licensed to Practice Medicine. A member who is applying for or receiving weekly accident and sickness benefits **MAY BE REQUIRED** to have a Physical Examination by a Physician selected by the Plan.

Send Completed Form to Address Above

******** MEMBER – Complete This Section ********

MEMBER'S NAME: (*Last, First, MI*)	**MEMBER'S ADDRESS: (*Street, City, State, Zip Code*)**		
SOCIAL SECURITY: - -	**SEX:** MALE FEMALE	**DATE OF BIRTH:** _____/_____/_____	**TELEPHONE:** ( )

EMPLOYER NAME & ADDRESS: (*Street, City, State, Zip Code*)

ACCIDENT OR ILLNESS: (*How, When, Where?*)

ARE YOU PLANNING TO PURSUE LEGAL ACTION AGAINST ANY OTHER PARTY OR FILE A CLAIM WITH AN INSURANCE COMPANY?
_____ YES _____ NO

IS THIS CONDITION WORK RELATED? _____ YES _____ NO

HAVE YOU OR WILL YOU FILE FOR WORKERS' COMPENSATION BENEFITS FOR THIS ACCIDENT / ILLNESS?
_____ YES _____ NO

WHERE WILL THE CLAIM BE FILED?

DATE OF ACCIDENT OR BEGINNING OF ILLNESS: _____/_____/_____	**INITIAL DATE OF TREATMENT / CARE:** _____/_____/_____	**INJURY DUE TO AUTO ACCIDENT?** _____ YES _____ NO

ARE YOU COVERED UNDER ANOTHER GROUP INSURANCE OR GOVERNMENT PLAN, SUCH AS MEDICARE, AN HMO PLAN, AUTOMOBILE MANDATORY NO-FAULT COVERAGE, UNINSURED MOTORIST OR HOMEOWNERS' INSURANCE, WHICH WILL ALSO COVER ANY OF THE MEDICAL EXPENSES OR DISABILITY LOSSES OF THIS CLAIM?
_____ YES _____ N O

NAMES OF ALL INSURANCE CARRIERS AND OTHER PLANS:

RELEASE OF INFORMATION: I hereby authorize this plan and/or any hospital, physician, pharmacy, insurance company, employer or organization to release or exchange any Information and records regarding my or my minor dependents' medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable concerning claims or utilization of Plan providers. This includes disability or employment related information. This data may also be extracted for use in audit or statistical purposes.

FALSE INFORMATION: I understand that any person, who knowingly files a false or incomplete claim or conceals information related to the claim, commits a fraudulent act and may be guilty of a crime. I further understand that a member, spouse and dependent children may lose coverage and be required to repay all amounts paid by the Plan and all costs of collection, including interest and attorney's fees.

TAXABILITY OF BENEFITS: I understand these payments are taxable and that I may authorize federal income tax withholding by signing the enclosed form.

MEMBER'S SIGNATURE_____ DATE_____

****** EMPLOYER – Complete This Section ******

DATE MEMBER WAS EMPLOYED?

_____/_____/_____ (*Month, Day, Year*)

DATE MEMBER LAST WORKED PRIOR TO DISABILITY:

_____/_____/_____ (*Month, Day, Year*)

WERE WAGES PAID FOR DAYS SUBSEQUENT TO LAST DAY OF WORK (*i.e., Vacation or Sick Pay*)? _____ YES _____ NO
(*If Yes*) LAST DATE FOR WHICH WAGES WERE PAID _____/_____/_____

IS DISABILITY DUE TO EMPLOYMENT? _____ YES _____ NO
(*If Yes, Explain*)

WILL CLAIM BE FILED FOR WORKERS' COMPENSATION BENEFITS? _____ YES _____ NO

IS WORKERS' COMPENSATION CLAIM CONTESTED? _____ YES _____ NO (*If Yes, ATTACH NOTICE OF CONTEST*)

HAS MEMBER RETURNED TO WORK?
_____/_____/_____ YES _____NO

IS LIGHT DUTY AVAILABLE (*IF REQUESTED*)?
_____ YES _____ NO

MEMBER'S EARNINGS FOR THE PRIOR 8 WEEKS BEFORE COMMENCEMENT OF DISABILITY:
(*Please Indicate ANY Vacation Pay issued with a (V) where appropriate*)

WEEK	WEEK ENDING DATE	AMOUNT
#1	_____/_____/_____	$_____
#2	_____/_____/_____	$_____
#3	_____/_____/_____	$_____
#4	_____/_____/_____	$_____
#5	_____/_____/_____	$_____
#6	_____/_____/_____	$_____
#7	_____/_____/_____	$_____
#8	_____/_____/_____	$_____

EMPLOYER:

TELEPHONE:

( )

EMPLOYER'S ADDRESS: (*Street, City, State, Zip Code*)

EMPLOYER'S SIGNATURE: _____ TITLE: _____ DATE: _____/_____/_____

****** PHYSICIAN – Complete This Section ******

(TO BE COMPLETED BY A LICENSED PRACTICING M.D)

PATIENTS NAME:

DATE OF INITIAL CONSULT: _____/_____/_____

DISABILITY DATES: (*Month, Day, Year*) FROM: _____/_____/_____ TO: _____/_____/_____

MOST RECENT TREATMENT DATE: _____/_____/_____
TREATMENT PERFOMED? (*Explain*)
_____
_____
_____

WAS SURGURY PERFORMED? _____YES _____ NO
(*If Yes, Explain*)
_____
_____
_____

IS DISABILITY DUE TO EMPLOYMENT?
_____ YES _____ NO

IS DISABILITY DUE TO AN AUTO ACCIDENT?
_____ YES _____ NO

DATE ABLE TO RETURN TO REGULAR JOB: (*Month, Day, Year*) _____/_____/_____

DIAGNOSIS OR NATURE OF ILLNESS AND/OR INJURY:

1.
2.
3.

PHYSICIAN'S TAX I.D OR SOCIAL SECURITY: (*Purpose Of Tax Reporting*) _____-_____-_____ Tax I.D: _____
PHYSICIAN'S ADDRESS: _____ TELEPHONE: (_____)_____

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

PHYSICIAN'S SIGNATURE: _____ DATE: _____