

TEAMSTER LOCAL 671 HEALTH SERVICES AND INSURANCE PLAN DISABILITY CLAIM FORM

PLEASE COMPLETE EVERY ENTRY ON THIS FORM. Have the reverse side of this form completed by your primary attending physician and employer.

Send this form to **TEAMSTERS LOCAL 671 HEALTH SERVICES PLAN**, 18 Britton Drive, Bloomfield, CT 06002, 860-243-0671

TO BE COMPLETED BY THE MEMBER

1. Member's Name		2. Member's Employer				
3. Member's Address		Street	City	State	ZIP	Phone
4. Date Last Worked	5. Member's ID Number	6. Members Birthdate				
		Mo.	Da.	Yr.		
7. Explain condition: (Accident or Illness:) If injury, please give full details (What, when, where and how)						
8. Is this condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, have you or will you file a claim for Workers Compensation benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Automobile Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No Motorcycle Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No						
9. Are you planning to pursue legal action or file a claim with another insurance company? <input type="checkbox"/> Yes <input type="checkbox"/> No						
10. Have you received advice, consultation or treatment for this condition/symptoms within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when _____ mo. _____ day _____ yr. If yes, please give full details						
11. Are you insured under another medical expense plan, or automobile coverage, which will also cover any of the medical expenses or disability losses of this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No						
12. If you answered yes to 11, above, give name of Insurance Company or organization providing benefits: Name: _____ Policy # _____						

Please be sure to contact your employer to inquire about possible F.M.L.A. benefits.

I hereby authorize any physician, hospital, pharmacy, insurance company, employer or organization, to release any information regarding the medical history, treatment, disability, or benefits payable for this claim to Teamsters Local 671 Health Services Plan, 18 Britton Drive, Bloomfield, CT 06002.

An exact copy of this authorization shall be as valid as the original.

Member's Signature: _____ Date: _____

Physician – Complete this Section

Patients Name: _____ D.O.B.: _____

Date first consulted for this condition: _____

Dates of total disability: From _____ through _____ Date able to return to work: _____

Describe present condition: _____

Surgical procedure, if any: _____

Date performed: _____ Place performed: _____ In Patient Out Patient

Is patient still under care for this condition? Yes No

If discharged, give date: _____ Next appointment: _____

Is condition due to? Employment Yes No
 Accident Yes No

If yes, please give details: _____

Physician Name: _____ Tax ID #: _____ Telephone #: _____
 _____ Fax #: _____

Address: _____

Signature: _____ Date: _____

Employer - Complete this Section

Member Name: _____ Telephone #: _____
 Employer Name: _____ Fax #: _____

Date member was employed:	Date member last worked prior to disability: Were wages paid subsequent to last day worked: <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain:	Is member still employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please give last day worked:
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Is disability due to employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will a claim be filed for Workers Compensation benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Is Workers Compensation claim being contested? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please attach copy.
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Has member returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is light duty available if requested? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Members earnings for the 8 weeks prior to commencement of disability - Please indicate any sick/vacation pay with a (✓) where appropriate.

Week ending date	Amount	Week ending date	Amount	Week ending date	Amount
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Employer's Representative Signature _____ Title _____ Date _____