

**TEAMSTERS LIFE WITH DUES BENEFIT PLAN
DISABILITY CLAIM STATEMENT**

T.D. # _____

RETURN THIS FORM TO YOUR LOCAL UNION

TO BE COMPLETED BY MEMBER

Female Male

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Please Print or Type Full Name of Member Name of Last Employer Local Union Number

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Home Address Address

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City, ST, Zip Code City, ST, Zip Code

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Date of Birth Height Weight Social Security Number Occupation Date Last Worked

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Date Disability Began Cause of Disability (If accident, please specify when and how it happened)

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Name of Present Physician Named of Hospital (if now or during past year, confined)

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Address Address

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City, ST, Zip Code City, ST, Zip Code

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Date First Treated for This Disability Date Last Treated for this Disability Date Admitted Date Released

If not hospitalized were you confined to your: House Yes No Bed Yes No

If not confined, what activities, if any, can you perform?

Give names and addresses of any other physicians

Give source and amount of present income derived from other than insurance policies

List insurance carrier under which you receive a waiver of premium or income benefit due to disability

TO BE COMPLETED BY LOCAL UNION

Member was in good standing in this organization from _____ through _____ with dues paid through _____

Our records show that the member named above
 had had not
qualified with the eligibility requirements under this plan on date disability commenced.

Name of Local Union

Signature of Principal Officer

Title Date

TO BE COMPLETED BY PLAN ADMINISTRATOR

Our records show that the member named above
 had had not
qualified with the eligibility requirements under this plan on date disability commenced.

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Date through which contributions paid for this Local	Class of Local	Amount of Benefit on Date Disability Commenced

Signed By

Approved Effective Date

Title Date

**AUTHORIZATION FOR RELEASE OF INFORMATION
TEAMSTERS LIFE WITH DUES BENEFIT PLAN**

I AUTHORIZE any physician, medical examiner or practitioner, coroner, hospital, Veterans Administration Hospital, clinic, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, employer or group policy holder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the Plan Member named below to give to Teamsters Life With Dues Benefit Plan or their legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by Teamsters Life With Dues Benefit Plan to determine eligibility for benefits under the Plan. Any information obtained will not be released by the Plan Administrator to any person or organization except to the participant's Local Union, the Medical Information Bureau, Inc., contract holder, or other personnel or organizations performing business or legal services in connection with this claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid during the duration of this claim.

Member's Name

Member's Signature

Date

7. PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)

- Class 1 - No limitation of functional capacity; capable of heavy work*. No restrictions. (0-10%)
- Class 2 - Medium manual activity.* (15-30%)
- Class 3 - Slight limitation of functional capacity; capable of light work.* (35-55%)
- Class 4 - Moderate limitation of functional capacity; capable of clerical/ administrative (sedentary) activity.* (60-70%)
- Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary) activity.* (75-100%)

Remarks:

8. MENTAL/ NERVOUS IMPAIRMENT (if applicable)

- Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations).
- Class 2 - Patient is able to function in most stress situation and engage in most interpersonal relations (slight limitations).
- Class 3 - Patient is able to engage in only limited stress situations and limited interpersonal relations (moderate limitations).
- Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
- Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).

Remarks:

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? Yes No

9. PROGNOSIS

<p>a) Is patient now totally disabled? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>b) What duties of patient's job is he/she incapable of performing?</p> <p>Do you expect a fundamental or marked change in the future? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>1. If yes, when will patient recover sufficiently to perform duties? <u> </u> / <u> </u> / <u> </u> <small>MM DD YY</small></p> <p>2. If no, please explain: <input type="checkbox"/> 1 Mo. <input type="checkbox"/> 3-6 Mos. <input type="checkbox"/> 1-3 Mos. <input type="checkbox"/> Never</p>	<p style="text-align: center;">PATIENT'S JOB</p>	<p style="text-align: center;">ANY OTHER WORK</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><u> </u> / <u> </u> / <u> </u> <small>MM DD YY</small></p> <p><input type="checkbox"/> 1 Mo. <input type="checkbox"/> 3-6 Mos. <input type="checkbox"/> 1-3 Mos. <input type="checkbox"/> Never</p>
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10. REHABILITATION

<p>a) Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc.?) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>b) Can present job be modified to allow for handling with impairment? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>c) When could trial employment commence?</p>	<p style="text-align: center;">PATIENT'S JOB</p> <p><u> </u> / <u> </u> / <u> </u> <small>MM DD YY</small></p> <p><input type="checkbox"/> Full Time <input type="checkbox"/> Part Time</p>	<p style="text-align: center;">ANY OTHER WORK</p> <p><u> </u> / <u> </u> / <u> </u> <small>MM DD YY</small></p> <p><input type="checkbox"/> Full Time <input type="checkbox"/> Part Time</p>
<p>d) Would vocational counseling and/or retraining be recommended? Yes <input type="checkbox"/> No <input type="checkbox"/></p>		

11. REMARKS

Name of Attending Physician (Print)	Degree
Address	Telephone Number
City, State, Zip Code	Individual Practitioner's S.S. #
Signature	Date Signed
	All Others - Employer I.D. #