**TEAMCARE - A NATIONAL TEAMSTER HEALTH PLAN**
**NOTICE OF CLAIM**

PARTICIPANT'S LOCAL NO.: ______________ DATE: ______________

In order to apply for **DEATH** and **ACCIDENTAL DEATH BENEFITS**, please complete this form and follow the instructions set forth below:

(Please type or print)

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| 1 | Participant's Name: (Last) (First) (MI) | Date of Birth: | Participant ID Number: |
| | Participant's Address (No. Street, City, State, Zip Code): | Participant's Phone: | Occupation: |
| 2 | Name and Address of Employer: | Date Last Worked: | |
| 3 | Was Participant on Medicare? ☐ Yes ☐ No **If Yes, send us a copy of your Medicare Card** | | |
| 4 | If the Participant's death certificate indicates divorced, please give date: | | |
| 5 | Type of Claim (Check One) | ☐ Participant Death<br>☐ Participant Accidental Death<br>☐ Dependent Spouse Death<br>☐ Dependent Child Death | ☐ Participant Total & Permanent Disability (Under age 50 on date of disability)<br>☐ Participant Total & Permanent Disability (Ages 50 thru 59 on date of disability) |
| 6 | Name and Address of Applicant for Benefits:<br>______________<br>______________<br>______________<br>(If more than one applicant, use back of form) | Telephone No.: ______________<br>Relationship to Participant: ______________ | |

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| **7**<br>Please attach the indicated documents to this Notice of Claim | **FOR PARTICIPANT DEATH** | Participant had Waiver of Premium: Claim No.: ______________<br>Participant was on TPD: Claim No.: ______________ |
| **ALL DEATH CLAIMS MUST HAVE CERTIFIED DEATH CERTIFICATE** | **FOR ACCIDENTAL DEATH** | • Include police, autopsy and toxicology reports when available |
| | **FOR DEPENDENT SPOUSE OR CHILD DEATH** | • Copy of Birth Certificate for Child Death<br>• Copy of Marriage Certificate for Spouse Death |
| | Name: ______________ | Relationship to Participant: ______________ |
| *Form is available from TeamCare - A National Teamster Health Plan, by calling 1-800-323-5000 or visiting our website at www.MyTeamCare.org | **FOR PARTICIPANT TOTAL & PERMANENT DISABILITY / WAIVER OF PREMIUM** | • Claimant's/Employer's Statement Sections 1 and 2*<br>• Doctor's Statement Section 3*<br>• Copy of Social Security Award<br>• Copy of Birth Certificate or Driver's License<br>• Completed and Signed Health and Welfare Designation of Beneficiary Form* |
| | Date of Disability: ______________ | |

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| 8 | Mail this completed Notice of Claim with the requested Documents to:<br>**TeamCare - A National Teamster Health Plan**<br>**Life Insurance Department**<br>**PO Box 5116**<br>**Des Plaines, IL 60017-5116** | ______________<br>Signature of Applicant(s) |