TEAMCARE
A NATIONAL TEAMSTER HEALTH PLAN

Local Union
Claim No.

SHORT-TERM DISABILITY CLAIM FORM – REPORT OF CONTINUED DISABILITY

Return Completed Form To: Central States/TeamCare, PO Box 5107 Des Plaines IL 60017-5107
or
Fax Form To: 847-518-9757

MEMBER

Participant ID: _____ Employer: _____

Full Name: _____ Address: _____

By signing below, I am certifying that I have not returned to work or retired:

_____ Signature of Participant

_____ Participant's Phone Number

_____ Date

PHYSICIAN

Patient's Name: _____

Have any complications or other conditions arisen since the last medical update? ☐ Yes ☐ No

If yes, please explain: _____

Please list all dates of treatment related to this disability:

Office Visits: _____ Surgery/Hospital Date(s): _____

ACTUAL OR ESTIMATED RETURN TO WORK DATE REQUIRED

Actual Return to Work Date: _____ **OR** **Estimated** Return to Work Date: _____

Physician's Signature: _____ **Print Physician's Name:** _____

Physician's Phone Number: _____ Date Form Completed: _____

EMPLOYER

THIS SECTION REQUIRED ONLY IF PARTICIPANT HAS RETURNED TO WORK

What date did the employee actually return to work (do not use a future date)? _____

Please verify the last day paid or compensated (i.e., vacation)? _____

Employer Signature: _____ Printed Name: _____

Employer Phone Number: _____ Date Form Completed: _____

Short-Term Disability Continuation Form

General Information

➜ **Please do not use this form to report a new period of disability.** The Initial Report of Disability Form must be completed for *each new period* of time off work.

➜ Once Short-Term Disability Benefits begin, we will notify you of the date payments end. You may be asked to submit an additional Continuation Form if you need further Short-Term Disability Benefits. To obtain a Continuation Form, contact our Participant Services Department at 1-800-323-5000 or visit our website at www.MyTeamCare.org.

UPS Participants: If you exhaust your 26 weeks of Short-Term Disability Benefits, you may be eligible for long-term disability benefits through UPS. To determine your eligibility, please call 1-800-877-1508.

Non-UPS Participants: If you exhaust your 26 weeks of Short-Term Disability Benefits, you may be eligible to make Self-Payments or receive an Extension of Benefits to continue health and welfare coverage. Please contact our Participant Services Department at 1-800-323-5000 if you need further information.

Physician's Supplementary Statement

➜ If the physician extended your return to work date since your last medical update, your physician should provide an explanation to support the change in your condition, as noted on the front of this form. Additional supporting documentation, such as the physician's office notes, may be required.

➜ All dates of treatment since the last report are required. Regular medical care is required to receive Short-Term Disability Benefits. If regular treatment is not needed, please ask your physician to submit an explanation.

➜ An actual or estimated date for your return to work is required. If left blank or stated as unknown, automatic payments will be affected.

Employer's Statement

➜ Employer's Statement is only required if you have returned to work.

Please call 1-800-323-5000 if you return to work prior to the date given by your doctor.