TEAMCARE - A NATIONAL TEAMSTER HEALTH PLAN
NOTICE OF CLAIM

PARTICIPANT'S LOCAL UNION NO.: _____ DATE: _____

In order to apply for **TOTAL & PERMANENT DISABILITY/WAIVER OF PREMIUM BENEFITS**, please complete this form and follow the instructions set forth below:

(Please type or print)

1	Participant's Name: (Last)	(First)	(MI)	Date of Birth:	Participant's 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	Type of Claim (Check One)	☐ Participant Death ☐ Participant Accidental Death ☐ Dependent Spouse Death ☐ Dependent Child Death		☐ Participant Total & Permanent Disability (Under age 50 on date of disability) ☐ Participant Total & Permanent Disability (Ages 50 thru 59 on date of disability)	
5	Name and Address of Applicant for Benefits: _____ _____ _____ (If more than one applicant, use back of form)			Telephone No.: _____ Relationship to Participant: _____	

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Please attach the indicated documents to this Notice of Claim

ALL DEATH CLAIMS MUST HAVE CERTIFIED DEATH CERTIFICATE

*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 DEATH
Participant had Waiver of Premium: Claim No.: _____
Participant was on TPD: Claim No.: _____

FOR ACCIDENTAL DEATH
- Include police, autopsy and toxicology reports when available

FOR DEPENDENT SPOUSE OR CHILD DEATH
- Copy of Birth Certificate for Child Death
- Copy of Marriage Certificate for Spouse Death

Name: _____ Relationship to Participant: _____

FOR PARTICIPANT TOTAL & PERMANENT DISABILITY / WAIVER OF PREMIUM
- Claimant's/Employer's Statement Sections 1 and 2*
- Doctor's Statement Section 3*
- Copy of Social Security Award
- Copy of Birth Certificate or Driver's License
- Completed and Signed Health and Welfare Designation of Beneficiary Form*

Date of Disability: _____

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Mail this completed Notice of Claim with the requested Documents to:

TeamCare - A National Teamster Health Plan
Life Insurance Department
PO Box 5116
Des Plaines, IL 60017-5116

_____
Signature of Applicant(s)

TEAMCARE - A NATIONAL TEAMSTER HEALTH PLAN

SECTION 1 – CLAIMANT'S STATEMENT – TOTAL AND PERMANENT DISABILITY

PLEASE TYPE OR PRINT IN INK

CLAIM NUMBER: _____

PARTICIPANT'S LOCAL UNION NO.: _____

PARTICIPANT'S ID NUMBER: _____

The Participant is responsible for the completion of this form without expense to TeamCare - A National Teamster Health Plan. A delay in processing may occur if all sections are not completed.

Full Name of Participant:			Date of Birth:
Occupation at time disability started:			
Name and Address of Last Employer:			
Give exact date you last worked for wage or profit:			
What were your exact duties of your last occupation?			
Describe all conditions which cause you to be totally disabled:			
Was disability the result of an on the job illness or injury?	☐ Yes	☐ No	
Has Social Security approved your disability claim? If **Yes, Attach Copy of Award**	☐ Yes	☐ No	☐ Pending

_____ _____

Claimant's Signature or Guardian's Signature — Date Signed

SECTION 2 – EMPLOYER'S STATEMENT – TOTAL AND PERMANENT DISABILITY

This statement must be completed by the Employer, or his duly authorized agent, as a Superintendent, Paymaster, etc.

(a)	Is Participant's present leave of absence resulting from an on the job *injury*?	☐ Yes	☐ No	☐ Disputed
(b)	Were/are you required to continue making H&W contributions on the Participant's behalf after the last day of work?	☐ Yes	☐ No	
(c)	If so, for what dates were/are you required to make these remittances? **FROM**: (Month) (Day) (Year) **TO:** (Month) (Day) (Year)			
(d)	What is actual last day worked? (Month) (Day) (Year)			

_____ _____ _____

Signature — Official Position — Date

MAIL COMPLETED FORM TO:

TEAMCARE - A NATIONAL TEAMSTER HEALTH PLAN
LIFE INSURANCE DEPARTMENT
PO BOX 5116
DES PLAINES IL 60017-5116

TEAMCARE - A NATIONAL TEAMSTER HEALTH PLAN

PARTICIPANT'S NAME: _____ CLAIM NUMBER: _____

PARTICIPANT'S ID NUMBER: _____

SECTION 3 – ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

1. DIAGNOSIS

2. PRESENT CONDITION

   a. Subjective symptoms

   b. Objective findings

   The results of x-rays, E.K.G.s, or any other special studies will be appreciated

3. DEGREE OF DISABILITY

	REGULAR OCCUPATION	ANY OCCUPATION
a. When was Participant obliged to cease work?	_____ Date	_____ Date
b. Has the Participant been able to do any work? If so, from what date?	_____ Date	_____ Date
c. If not, approximately when do you think he/she will be able to return to work?	_____ Date	_____ Date

OR

☐ INDEFINITE ☐ NEVER

4. CARDIAC

   Functional Capacity (AHA)

   Class 1 (No Limitation) Class 2 (Slight Limitation) Class 3 (Marked Limitation) Class 4 (Complete Limitation)

5. PROGRESS ☐ Improved ☐ Unimproved ☐ Retrogressed

6. TREATMENT

   a. Current Frequency of Visits ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly

   b. When did you last examine the Participant? _____ Date

7. REMARKS:

_____ Signature of Physician _____ Date Signed _____ Phone Number

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LIFE INSURANCE DEPARTMENT
PO BOX 5116
DES PLAINES IL 60017-5116