MO-KAN TEAMSTERS HEALTH & WELFARE FUND

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DISABILITY BENEFITS FORM

Member and Physician must complete this form in full.

CLAIMANT'S STATEMENT (MEMBER)

Name _____ SS# _____

Address _____

Is disability due to an accident or injury? _____ If yes, please provide details: _____

_____

Have you filed or do you intend to file worker's compensation? _____

Last date worked: _____ Have you returned to work? _____ If so, when? _____

If not, when do you expect to be able to return to work? _____

Date: _____ Signed: _____

ATTENDING PHYSICIAN OR SURGEON'S STATEMENT

Patient's Name: _____

Nature of sickness of injury: _____

_____

Date patient first consulted you: _____

To your knowledge, has the patient filed or intended to file worker's compensation? _____

Patient has been continuously disabled (unable to work): Date of next appointment:

From (date): _____ (date) _____

Through (date): _____

If still disabled, approximately when should patient be able to return to work? _____

Date: _____ Signed: _____

Name (printed): _____

Address: _____

Phone: _____