PROOF OF DISABILITY CLAIM FORM

Send completed form to:
Teamsters Benefit Trust (TBT) • P.O. Box 5820 • Fremont, CA 94537-5820 • (510) 796-4676 • (800) 533-0119 • Fax (510) 795-9237

PART I — TO BE COMPLETED BY THE EMPLOYEE (Please Print)

Name of Employer (Company Name)	***Date Hired*** (Month-Day-Year)	***Local Union Number***

Employee's Name (Last, First, Middle Initial) *Please Print*	Birth Date (Month-Day-Year)	Social Security Number

Home Address (*Please Print*) ❑ Check if new	City	State	Zip Code	Home Phone ( )

Date Last Worked (Month-Day-Year) A.M. _____ P.M. _____	Have you performed any work for wages during the period you are claiming disability benefits? YES ❑ NO ❑ If yes, dates? (Month-Day-Year)	Is disability due to an accident? YES ❑ NO ❑ Was it work-related? YES ❑ NO ❑

Nature of Sickness or Injury (If pregnancy, due date)

Date First Treated (Month-Day-Year)	Have you returned to work? YES ❑ NO ❑ If yes, date? (Month-Day-Year)	Please advise if light duty is available YES ❑ NO ❑ If yes, dates worked? (Month-Day-Year)

Date of Return to Work (Month-Day-Year)	Have you filed a prior claim with this office for this disability? YES ❑ NO ❑ If yes, date? (Month-Day-Year)

The above answers are true and complete according to the best of my knowledge and belief. I hereby authorize my attending physician, to furnish and disclose all facts concerning this disability.

Employee's Signature	Date Signed (Month-Day-Year)

PART II — ATTENDING PHYSICIAN'S STATEMENT (Please Print)

Patient's Name and Address

ICD-10 Diagnostic Code and description (Must provide clear and accurate ICD-10 code. If pregnancy, give E.D.C.)

Dates of Services (If previous form submitted to this plan, you only need to show dates since last report)

Patient was continuously totally disabled (unable to return to work) From: (Month-Day-Year) To: (Month-Day-Year)	Patient was partially disabled From: (Month-Day-Year) To: (Month-Day-Year)

If still disabled, date patient should be able to return to work (Month-Day-Year)	Patient was hospital confined From: (Month-Day-Year) To: (Month-Day-Year)

Date (Month-Day-Year)	Physician's Name and Degree (print) (MD or DO required)	Signature	Telephone ( )

Individual Practitioner's Social Security Number	All Others—Employer NPI/TAX ID Number (Required by law)

Street Address	City	State	Zip Code