CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND

Disability Application Accident Details

This form to be filled out by the member, doctor and employer immediately after the commencement of disability and forwarded to the Fund office address:
Central PA Teamsters H&W Fund, P.O. Box 15224, Reading, PA 19612-5224
IMPORTANT! All claims must be submitted within 1 year, to insure payment.

Name of Member | Identification No: CPT

Address Street | City | State | Zip Code | Email: | Phone ( )

Sex | Age | Member of Local Union No. | Employer | Job Classification

Do you have any other Group Health ins.? No ☐ Yes ☐
If yes, give name of carrier________________________________
Carrier Phone No. ( ) Eff date:

Do you or your family have any other Non-Group Health Insurance?
No ☐ Yes ☐
If yes, give name of carrier________________________________
Phone No. ( ) Eff date:

Does your spouse have any other Group Health Ins? No ☐ Yes ☐
If yes, give name of carrier________________________________
Carrier Phone No. ( ) Eff Date:
What type of coverage did your spouse elect? Single ☐ Family ☐
Does this insurance provide and HSA? No ☐ Yes ☐
Does this insurance provide and HRA? No ☐ Yes ☐

DEPENDENT INFORMATION

Name of Dependent | Relationship | Sex | Birthdate

Does Dependent Work? No ☐ Yes ☐; *If yes, do they have any other Group Ins?* No ☐ Yes ☐
Carrier name: *Carrier Phone No. ( )* *Eff Date:*
Employer Name:
Phone No. ( )

STATEMENT OF SICKNESS OF ACCIDENT (Must Be Completed By Member)

1. Date Sickness began or Accident occurred
2. If Accident, how did it happen?
3. Where did Accident happen? — On the Job? No ☐ Yes ☐
4. Name of Sickness or Nature of Injury
5. Date of first medical treatment for this disability — Where?
6. Name of Doctor

ATTENDING PHYSICIAN'S STATEMENT- Member not allowed to complete this section.

1. Name of Patient	
2. Date Sickness began or Accident occurred	
3. Nature of Sickness or Nature of Injury	
4. Dates of all Medical Treatments	Office: Home: Hospital:
5. If patient was hospitalized	Where? From: To:
6. If an operation was performed	What?
7. When in your opinion will the patient be able to work? (*Must be completed to open a disability)*	Date:

ITEMIZED BILLS FOR HOSPITAL, SURGICAL AND MEDICAL EXPENSE MUST BE SUBMITTED ON A HCFA OR UB04

Physician's Signature: ______________________________ Date:_________ Non Corp. S.S.#______________________
Address: ___________________________ City: _____________ State: ____ Zip:_____ Corp. Federal I.D. #____________________

RELEASE: The statements are true and correct to the best of my belief. I hereby authorize any provider of services to furnish any information requested. I also hereby authorize my Health and Welfare Fund Administrator to release or obtain from any organization or person information which may be necessary to determine benefits payable under my Health and Welfare Plan. A photo static copy of this authorization shall be considered as effective and valid as the original.
Signed ____ Date _______________
(Must Be Signed By Member Only)

Employer's Statement – Member not allowed to complete this section.

1. Date of first full working day lost because of Sickness or Accident. — Date resumed work
2. Was claimant regularly employed and working for you when disability began? — Date employed
3. Is this being reported under Workmen's Compensation?

Print Legible
DATE:
Employer's Name/Official Position:
Preferred Method of Contact: Phone ☐ Email ☐ Time of day ______
Employer Phone No. ( )
Employer Email: