CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND Disability Application For Benefits Accident Details	This form to be filled out by the member, doctor and employer immediately after the commencement of disability and forward to the Fund office. Mailing Address: Central PA Teamsters H&W Fund, P.O. Box 15224, Reading, PA 19612-5224 Email: hwfund@centralpateamsters.com Fax: 610-320-9236 **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:	Does your spouse 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:	If yes above, what is the type of coverage did your spouse elect? Single ☐ Family ☐ Other ☐ Does this insurance provide an HSA? No ☐ Yes ☐ Does this insurance provide an 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?
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- (Must Be Completed By Physician – Not the Member)

1.	Name of Patient	
2.	Date Sickness began or Accident occurred	
3.	Nature of Sickness or 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 – (Must Be Completed By the Employer – Not the Member)

1.	Date of first full working day lost?	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 Telephone No. ( )** **Email:**