



**ALASKA TEAMSTER-EMPLOYER WELFARE TRUST
REQUEST FOR BENEFITS**

520 E 34th Ave, Suite 107 Anchorage, Alaska 99503-4116
907/565-8300 800/478-4450

Email: benefits@959trusts.com

STATEMENT OF CLAIM FOR WEEKLY DISABILITY BENEFITS

TO BE COMPLETED BY THE EMPLOYEE

Employee Name: _____

Mailing Address: _____

Social Security Number: _____ Birth Date: _____

1) Date you were first unable to work: _____

Was disability due to an accident? Yes No

Is condition work related? Yes* No

* If YES, give date of accident and brief explanation: _____

Employee Signature: _____ Date: _____

ATTENDING PHYSICIAN'S STATEMENT

1) Nature of illness or injury: _____

2) Is condition work related? Yes No

3) Date of first treatment: _____

4) Date of most recent treatment: _____

5) Date of next office treatment: _____

6) The patient has been continuously disabled (unable to work) from _____ to _____

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

PHYSICIAN'S SIGNATURE: _____ DATE: _____

MAILING ADDRESS: _____

TELEPHONE: (_____) _____