ALASKA TEAMSTER-EMPLOYER
WELFARE TRUST

STATEMENT OF CLAIM
FOR WEEKLY DISABLITY BENEFITS

PART ONE: TO BE COMPLETED BY EMPLOYEE

Employee Name: _____

Mailing Address: _____

Medical ID #: _____Date of Birth: _____

Date you were first unable to work: _____

Was disability to an accident? ☐ YES ☐ NO

Is condition work related? ☐ YES ☐ NO

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

_____

Employee Signature: _____ Date: _____

PART TWO: ATTENDING PHYSICIANS STATEMENT

Nature of illness or injury: _____

Is condition work related? ☐ YES ☐ NO

Date of first treatment: _____

Date of most recent treatment: _____

Date of next office treatment: _____

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

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

PHYSICIAN'S SIGNATURE: _____DATE: _____

Mailing Address: _____

Telephone: (_____) _____

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