

SOUTHWESTERN TEAMSTERS SECURITY FUND

Administrator:
Southwest Service Administrators, Inc.
 2400 W. Dunlap Ave., Suite 250
 Phoenix, Arizona 85021

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Toll free (800) 474-3485
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PARTICIPANT STATEMENT:

DISABILITY / TIME LOSS BENEFITS			
PART A		EMPLOYEE'S STATEMENT (MUST BE COMPLETED BY EMPLOYEE)	
1. EMPLOYEE NAME (PLEASE PRINT)		2. BIRTH DATE MO. DAY YR	3. SOCIAL SECURITY NO. / /
4. ADDRESS <input type="checkbox"/> CHECK HERE IF NEW ADDRESS		CITY STATE ZIP	5. PHONE NO. ()
6. EMPLOYER (Or Company you work for)			
6 a. ADDRESS		CITY STATE ZIP	7. PHONE NO. ()
8. IS THIS CLAIM FOR AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
9. IF YES – WHERE DID IT HAPPEN?			
10. WHEN? MO DAY YR		11. DID THIS ACCIDENT/INJURY OCCUR ON THE JOB? <input type="checkbox"/> YES <input type="checkbox"/> NO	
12. NAME AND ADDRESS OF PERSON RESPONSIBLE FOR ACCIDENT OR INJURY:			
13. NAME, ADDRESS AND CLAIM NUMBER OF RESPONSIBLE PERSON'S INSURANCE COMPANY:			
14. EMPLOYEE STATEMENT AND AUTHORIZATION TO RELEASE INFORMATION: I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning this disability. I will reimburse the fund for any overpayment made to me or in my behalf due to error on this form. I understand that it is a federal crime, punishable by fine or imprisonment, or both, to knowingly make false statements on this benefit claim form. <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 45%; text-align: center;"> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Employee Signature </div> <div style="width: 45%; text-align: center;"> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Date </div> </div>			
CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE			

EMPLOYER / HUMAN RESOURCE STATEMENT:

PART B (MUST BE COMPLETED BY EMPLOYER / HUMAN RESOURCE DEPARTMENT)			
1. LAST DAY WORKED	2. DATE RETURNED TO WORK	3. DID INJURY OCCUR ON THE JOB? <input type="checkbox"/> YES <input type="checkbox"/> NO	
4. COMPANY NAME	5. SIGNED BY	6. TITLE	7. DATE

PART C PHYSICIAN'S STATEMENT FOR SHORT-TERM DISABILITY (MUST BE COMPLETED BY PHYSICIAN FOR PATIENT BEING DISABLED 6 MONTHS OR LESS)			
1. PATIENT'S NAME: (PLEASE PRINT)		2. SOCIAL SECURITY NUMBER:	
3. ICD.9 CODE WITH DESCRIPTION		4. IF DIAGNOSIS IS PREGNANCY, PLEASE LIST DUE DATE:	
5. DATE PATIENT DISABLED FROM WORK:	6. *DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK: *MANDATORY	7. DATE PATIENT RELEASED TO RETURN TO WORK:	
8. FEDERAL TAX ID NUMBER:	9. PHONE NUMBER:	10. FAX NUMBER:	
11. PHYSICIAN NAME & ADDRESS: (PRINT)		12. PHYSICIAN'S SIGNATURE:	13. DATE: