Please send completed form to:

Claims Management Corporation
Post Office Box 419797
Kansas City, Missouri 64141
Telephone: 1-800-821-5401
Fax: 1-866-486-5243

TRUCKER OCCUPATIONAL ACCIDENT PLAN

DISABILITY CLAIM FORM

CMC

Instructions: Please have this claim form completed by both you and your attending Physician and IMMEDIATELY return to Claims Management Corporation. Be sure to answer all questions on your side of this form before asking your Physician to complete the reverse side. A partially completed claim form will be returned to you for completion and will delay our claim servicing. Thank you.

INITIAL CLAIMANTS STATEMENT – PLEASE PRINT

1. Claimant's Name: ______________________________
2. Social Security No.: ____________ Date of Birth: ____________ Height: ________ Weight: ________
3. Address: ______________________________
   Number and Street City State Zip Code
4. Leased to: ____________________ Motor Carrier Address: ____________________
5. Describe the duties of your job: ______________________________
6. Average gross monthly revenue $: ______________________________
7. Describe injuries fully: ______________________________
8. How did accident occur? ______________________________
9. Date and hour injury occurred? ______________________________
10. Was injury due to accident to vehicle in which you were riding? ______________________________
11. Type of vehicle and license number: ______________________________
12. Have you ever had similar injury? Yes ❒ No ❒ If yes, when? ______________________________
13. When did you cease all work? ____________ When did you first consult a physician? ____________
    Doctor's name and address: ______________________________
14. List all dates of treatment: ______________________________
15. On what date did you return to partial duties of your occupation? ______________________________
16. On what date did you resume all work? ______________________________
17. If confined to hospital, state name and address: ______________________________
18. Date admitted: ____________________ Date Discharged: ____________________
19. Name and address of family physician: ______________________________
20. What other insurance (life, accident, disability income, hospitalization) do you have? ______________________________

____

____

I hereby certify the above statements are true and correct, to the best of my knowledge.

______________________________ ____________
Signature Date

AUTHORIZATION

I authorize any licensed physician, medical practitioner, hospital (including Veteran's Hospital), clinic, employer or insurance company that has records or knowledge of me or my health, including diagnosis, treatment and prognosis of a physical or mental condition, to give CMC (Claims Management Corporation) any such information. I also authorize the release of this information to any agency employed by CMC to collect and transmit this information.

The purpose of this authorization is processing my claim and it will remain valid for 120 days from the date below.

I understand that upon request I may receive a copy of this authorization and that a photostatic copy will be as valid as the original.

______________________________ ____________
Claimant's Signature Date

Address: ______________________________

© 2000

TRUCKER OCCUPATIONAL ACCIDENT PLAN
INITIAL ATTENDING PHYSICIAN'S STATEMENT
- ACCIDENT -

Patient's Name: ____________________ Date of Birth: ____________

	Question	Response
1	Diagnosis (Describe complications including any other disease affecting present condition)	
2	Is claim for accident or sickness?	Accident ❐ Sickness ❐
3	If accident, do you have any knowledge as to how accident occurred? (If Yes, please describe).	Yes ❐ No ❐
4	When did symptoms first appear or accident happen?	Date ____________ ,20 ____
5	When did patient first consult you for this condition?	Date ____________ ,20 ____
6	Has patient ever had same or similar condition? (If yes, state when and describe)	Yes ❐ No ❐
7	Hospital name and dates confined:	______ from ______ ,20 ____ to ______ ,20 ____
8	Nature of surgical procedure, if any (Describe fully). Charge for this procedure and date performed. Where performed?	$ ______ Date ______ ,20 ____ ______ If in hospital, inpatient ❐ outpatient ❐
9	Give dates of treatment:	Charge Per Call Office ______ $ ______ Hospital ______ $ ______
10	Is patient still under your care for this condition? If discharged, give date.	Yes ❐ No ❐
11	How long was or will patient be continuously totally disabled? (Unable to do any duties of occupation)	______ from ______ ,20 ____ to ______ ,20 ____
12	How long was or will patient be partially disabled? (Unable to do one or more important duties)	______ from ______ ,20 ____ to ______ ,20 ____
13	Is condition due to injury arising out of patient's work? (If yes, please describe):	Yes ❐ No ❐
14	Are you this patient's family physician? (If no, please list the family physician's name and address)	Yes ❐ No ❐ Name: ______ Address: ______

Date ____________ , 20 ____ Signed ____________

Attending Physician

Phone #: ____________

Social Security or Tax ID Number:

Street Address ____ City or Town ____ State ____ Zip Code

© 2000