Please send completed form to:

Claims Management Corporation
Post Office Box 419797
Kansas City, Missouri 64141
Telephone: 1-800-821-5401
Fax: 1-816-218-0827

TRUCKER OCCUPATIONAL ACCIDENT PLAN

DISABILITY CLAIM FORM

CMC

SUPPLEMENTARY CLAIMANTS STATEMENT – PLEASE PRINT

NAME: ______________________________

UNIT NUMBER: ______________ SOCIAL SECURITY NUMBER: ______________

1. On what date were you able to return to one or more duties of your occupation? (Date you resumed partial duties.)
____
2. What duties were you able to perform as of that date? ______________________________
____
3. What duties were you unable to perform? ______________________________
____
4. What date did you return to full duties of your occupation? ______________ 20 ____
5. If you have not returned to full duties, when do you expect to do so? ______________ 20 ____
6. Have you been hospital confined since the date of our last payment? Yes ❒ No ❒ If yes, please list the name and address of the hospital, together with the date admitted and date discharged below: ______________
____
7. Are you presently house confined? Yes ❒ No ❒ If no, when were you first able to leave your home?
____

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
SUPPLEMENTARY ATTENDING PHYSICIAN'S STATEMENT
- ACCIDENT -

Patient's Name: ______________________ Date of Birth: ______________

1 Diagnosis (Accident or Sickness) (Describe complications, if any)	
2 Occupational or Non-Occupational?	Occupational ❐ Non-Occupational ❐
3 Describe any other diseases or infirmity affecting present condition.	
4 Give dates of treatment:	Office ______ Hospital ______
5 Hospital name and dates confined:	______ from ______ ,20 ____ to ______ ,20 ____
6. Is patient still under your care for this condition? If discharge, give date:	Yes ❐ No ❐ Date ______ ,20 ____
7. How long was or will patient be totally disabled? (Unable to do any duties of occupation)	______ from ______ ,20 ____ to ______ ,20 ____
8 How long was or will patient be partially disabled? (Unable to do one or more important duties)	______ from ______ ,20 ____ to ______ ,20 ____
9 Was patient confined to the house? If yes, date:	Yes ❐ No ❐ ______ from ______ ,20 ____ to ______ ,20 ____

10 PROGNOSIS (Including expected return to work date):

Date ______________ , 20 ______ Signed ______________________ , M.D.

Phone # : ______________ Social Security Number: ______________ or
Physician or Surgeon

Employer Identification Number: ______________

____

Street Address City or Town State Zip Code

© 2000