TEAMCARE® - A CENTRAL STATES HEALTH PLAN
DISMEMBERMENT APPLICATION FORM

THIS SECTION TO BE COMPLETED AND SIGNED BY THE CLAIMANT

CLAIMANT NAME: ______________________ **PARTICIPANT ID:** ______________

DATE OF BIRTH: ______________________ **LOCAL UNION NO.:** ______________

ADDRESS: ____
Street

____
City State Zip Code

DATE, DESCRIPTION & LOCATION OF ACCIDENT: ______________________________

____

____

HOSPITAL NAME & ADDRESS: ____
Name

____
Street

____
City State Zip Code

CLAIMANT SIGNATURE: ____
Signature Date

THIS SECTION TO BE COMPLETED AND SIGNED BY THE PHYSICIAN
(ATTACH COPIES OF OPERATIVE REPORT)

DATE & DESCRIPTION OF DISMEMBERMENT: ______________________________

____

IS THE DISMEMBERMENT A DIRECT RESULT OF THE ACCIDENT? ☐ YES ☐ NO

IS THE DISMEMBERMENT LOSS OF EYESIGHT? ☐ YES ☐ NO

WHICH EYES? ☐ RIGHT EYE ☐ LEFT EYE ☐ BOTH EYES

IS THE LOSS OF SIGHT TOTAL AND IRRECOVERABLE? ☐ YES ☐ NO

THE DATE IT WAS DETERMINED THAT PARTICIPANT LOST EYESIGHT: ______________

CURRENT VISUAL ACUITY WITH CORRECTION: ______________ **W/O CORRECTION:** ______________

COMMENTS: ____

____

____

PHYSICIAN SIGNATURE: ____
Signature Date

PHYSICIAN ADDRESS: ____
Street

____
City State Zip Code

PHYSICIAN TAX ID: ______________________ **TELEPHONE NO.:** ______________________

RETURN TO:

TEAMCARE - A CENTRAL STATES HEALTH PLAN
LIFE INSURANCE DEPARTMENT
PO BOX 5116
DES PLAINES, IL 60017-5116