**TEAMCARE® - A CENTRAL STATES HEALTH PLAN**
**NOTICE OF CLAIM**

PARTICIPANT'S LOCAL NO.: _____ DATE: _____

In order to apply for **DEATH** and **ACCIDENTAL DEATH BENEFITS**, please complete this form and follow the instructions set forth below:

(Please type or print)

| | | | |
|---|---|---|---|
| **1** | Participant's Name: (Last) (First) (MI) | Date of Birth: | Participant ID Number: |
| | Participant's Address (No. Street, City, State, Zip Code): • | Participant's Phone: | Occupation: |

| | | |
|---|---|---|
| **2** | Name and Address of Employer: | Date Last Worked: |

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|---|---|
| **3** | Was Participant on Medicare? ☐ Yes ☐ No **If Yes, send us a copy of your Medicare Card** |

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|---|---|
| **4** | If the Participant's death certificate indicates divorced, please give date: |

| | | | |
|---|---|---|---|
| **5** | Type of Claim (Check One) | ☐ Participant Death<br>☐ Participant Accidental Death<br>☐ Dependent Spouse Death<br>☐ Dependent Child Death | ☐ Participant Total & Permanent Disability (Under age 50 on date of disability)<br>☐ Participant Total & Permanent Disability (Ages 50 thru 59 on date of disability) |

| | | |
|---|---|---|
| **6** | Name and Address of Applicant for Benefits:<br>_____<br>_____<br>_____<br>(If more than one applicant, use back of form) | Telephone No.: _____<br>Relationship to Participant: _____ |

| | | |
|---|---|---|
| **7** | **FOR PARTICIPANT DEATH** | Participant had Waiver of Premium: Claim No.: _____<br>Participant was on TPD: Claim No.: _____ |
| Please attach the indicated documents to this Notice of Claim<br><br>**ALL DEATH CLAIMS MUST HAVE CERTIFIED DEATH CERTIFICATE** | **FOR ACCIDENTAL DEATH** | • Include police, autopsy and toxicology reports when available |
| | **FOR DEPENDENT SPOUSE OR CHILD DEATH** | • Copy of Birth Certificate for Child Death<br>• Copy of Marriage Certificate for Spouse Death<br>Name: _____ Relationship to Participant: _____ |
| *****Form is available from TeamCare by calling 800-TEAMCARE or visiting our website at MyTeamCare.org | **FOR PARTICIPANT TOTAL & PERMANENT DISABILITY / WAIVER OF PREMIUM** | • Claimant's/Employer's Statement Sections 1 and 2*<br>• Doctor's Statement Section 3*<br>• Copy of Social Security Award<br>• Copy of Birth Certificate or Driver's License<br>• Completed and Signed Health and Welfare Designation of Beneficiary Form*<br>Date of Disability: _____ |

| | | |
|---|---|---|
| **8** | Mail this completed Notice of Claim with the requested Documents to:<br>**TEAMCARE - A CENTRAL STATES HEALTH PLAN**<br>**LIFE INSURANCE DEPARTMENT**<br>**PO BOX 5116**<br>**DES PLAINES, IL 60017-5116** | _____<br>Signature of Applicant(s) |