TEAMCARE® - A CENTRAL STATES HEALTH PLAN
NOTICE OF CLAIM

PARTICIPANT'S LOCAL UNION NO.: ____________ DATE: ______________________

In order to apply for **TOTAL & PERMANENT DISABILITY/WAIVER OF PREMIUM 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's ID Number:
	Participant's Address (No. Street, City, State, Zip Code):	Participant's Phone:	Occupation:

2	Name and Address of Employer:	Date Last Worked:

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

4	Type of Claim (Check One)	☐ Participant Death ☐ Participant Accidental Death ☐ Dependent Spouse Death ☐ Dependent Child Death	☐ Participant Total & Permanent Disability (Under age 50 on date of disability) ☐ Participant Total & Permanent Disability (Ages 50 thru 59 on date of disability)

5	Name and Address of Applicant for Benefits: ______________________ ______________________ ______________________ (If more than one applicant, use back of form)	Telephone No.: ____________ Relationship to Participant: ____________

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

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

TEAMCARE - A CENTRAL STATES HEALTH PLAN

SECTION 1 – CLAIMANT'S STATEMENT – TOTAL AND PERMANENT DISABILITY

PLEASE TYPE OR PRINT IN INK

CLAIM NUMBER: ____________________

PARTICIPANT'S LOCAL UNION NO.: __________

PARTICIPANT'S ID NUMBER: ____________________

The Participant is responsible for the completion of this form without expense to TeamCare. A delay in processing may occur if all sections are not completed.

Full Name of Participant:	Date of Birth:
Occupation at time disability started:	
Name and Address of Last Employer:	
Give exact date you last worked for wage or profit:	
What were your exact duties of your last occupation?	
Describe all conditions which cause you to be totally disabled:	
Was disability the result of an on the job illness or injury?	☐ Yes ☐ No
Has Social Security approved your disability claim? **If Yes, Attach Copy of Award**	☐ Yes ☐ No ☐ Pending

Claimant's Signature or Guardian's Signature

Date Signed

SECTION 2 – EMPLOYER'S STATEMENT – TOTAL AND PERMANENT DISABILITY

This statement must be completed by the Employer, or his duly authorized agent, as a Superintendent, Paymaster, etc.

(a)	Is Participant's present leave of absence resulting from an on the job *injury*?	☐ Yes ☐ No ☐ Disputed
(b)	Were/are you required to continue making H&W contributions on the Participant's behalf after the last day of work?	☐ Yes ☐ No
(c)	If so, for what dates were/are you required to make these remittances? **FROM**: (Month) (Day) (Year) **TO:** (Month) (Day) (Year)	
(d)	What is actual last day worked? (Month) (Day) (Year)	

Signature

Official Position

Date

MAIL COMPLETED FORM TO:

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

TEAMCARE - A CENTRAL STATES HEALTH PLAN

PARTICIPANT'S NAME: ______________________ CLAIM NUMBER: ______________________

PARTICIPANT'S ID NUMBER: ______________________

SECTION 3 – ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

1. DIAGNOSIS

2. PRESENT CONDITION

   a. Subjective symptoms

   b. Objective findings

   The results of x-rays, E.K.G.s, or any other special studies will be appreciated

3. DEGREE OF DISABILITY

	REGULAR OCCUPATION	**ANY OCCUPATION**
a. When was Participant obliged to cease work?	______ Date	______ Date
b. Has the Participant been able to do any work? If so, from what date?	______ Date	______ Date
c. If not, approximately when do you think he/she will be able to return to work?	______ Date	______ Date

OR

☐ INDEFINITE ☐ NEVER

4. CARDIAC

   Functional Capacity (AHA)

   Class 1 (No Limitation) Class 2 (Slight Limitation) Class 3 (Marked Limitation) Class 4 (Complete Limitation)

5. PROGRESS ☐ Improved ☐ Unimproved ☐ Retrogressed

6. TREATMENT

   a. Current Frequency of Visits ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly

   b. When did you last examine the Participant? ______________________ Date

7. REMARKS:

______________________ Signature of Physician

______________________ Date Signed

______________________ Phone Number

MAIL COMPLETED FORM TO:

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

TEAMCARE®
A CENTRAL STATES HEALTH PLAN

LIFE INSURANCE BENEFICIARY DESIGNATION FORM

Return Completed Form To: Central States/TeamCare, PO Box 5116 Des Plaines IL 60017-5116

Please choose a beneficiary for your TeamCare - A Central States Health Plan Life Insurance Benefit by completing the appropriate box or boxes below. **Please type or print your response clearly.**

► PLEASE SIGN AND DATE THE FORM BEFORE RETURNING IT TO TEAMCARE. ◄

PARTICIPANT'S INFORMATION PLEASE PRINT

Legal Last Name	Legal First Name	MI	Participant's TeamCare ID Number
			8 0 6 _ _ _ _ _ _

PRIMARY LIFE INSURANCE BENEFICIARY, if living PLEASE PRINT

Beneficiary Last Name	Beneficiary First Name	MI	Relationship to Participant	Social Security Number

If you name more than one primary beneficiary, include all of the names in the spaces above. Please note that any benefit payable will be disbursed in equal shares to the named surviving beneficiary, unless otherwise noted.

CONTINGENT BENEFICIARY PLEASE PRINT

Beneficiary Last Name	Beneficiary First Name	MI	Relationship to Participant	Social Security Number

If the primary beneficiary should become deceased, you may name a contingent beneficiary, or beneficiaries, in the spaces above. Please note that any benefit payable will be disbursed in equal shares to the named surviving beneficiaries, unless otherwise noted.

By signing below, I revoke any previous designation and fully understand that the above beneficiary will remain in effect until such time that I complete a new Designation of Beneficiary form.* **This form must be signed and dated by the Participant to be valid.**

*** Please note: If a Covered Participant's marital status is terminated due to a final decree of divorce, ANY beneficiary designation running in favor of the Covered Participant's divorced spouse made by the Covered Participant prior to the final divorce decree, will be null and void. In this case the Participant must supply TeamCare with a properly executed Beneficiary Designation form, otherwise benefits will be payable pursuant to the preference provisions of Plan Section 14.09. Any beneficiary designated, prior to the final decree of divorce, and running in favor of persons OTHER THAN the former (now divorced) spouse will not be affected.**

Signature of Participant ______________________ Participant's Local Union ______________ Date Signed ______________

TEAMCARE
LIFE INSURANCE BENEFICIARY DESIGNATION FORM

Plan Default Provisions for Life Insurance Benefits

- In the event of your death and if you have not named a beneficiary or if the beneficiary you named is no longer living — the benefit amount will be paid in full to the first surviving class as follows:

  - Your surviving spouse;
  - Equal shares to your surviving children;
  - Equal shares to your surviving parents;
  - Equal shares to your surviving brothers and sisters; or
  - Your estate.

- In the event of an Accidental Dismemberment, the benefits will be paid to you after the Plan receives satisfactory proof of loss.

- It is important that you keep your beneficiary designations current to ensure benefits are distributed in accordance with your wishes when you die. The Plan must pay Life Insurance and Accidental Death or Dismemberment Benefits in accordance with valid beneficiary notices filed with the Plan.

- If you do not name a beneficiary, Life Insurance and Accidental Death or Dismemberment Benefits will be paid in accordance with the beneficiary order established by the Plan.