Return this Form to:

OREGON TEAMSTER EMPLOYERS TRUST
c/o WILLIAM C. EARHART CO., INC.
P.O. BOX 4148 – PORTLAND, OREGON 97208
PHONE: 503/282-5581 • WATS 1-800-547-1314

DO NOT ATTACH MEDICAL BILLS

STATEMENT OF DISABILITY CLAIM

PART 1 INSURED MEMBER COMPLETES

EMPLOYEE'S NAME (LAST) (FIRST) (INITIAL)		**EMPLOYER NAME** (OR COMPANY YOU WORK FOR)		
ADDRESS		DATE EMPLOYED	EMPLOYEE'S DATE OF BIRTH	
CITY, STATE	ZIP CODE	SOCIAL SECURITY NO.	LOCAL UNION NO.	HOME TELEPHONE NO.

NAME AND ADDRESS OF ANY OTHER INSURANCE CARRIER OR ORGANIZATION PROVIDING BENEFITS FOR THIS CLAIM (INCLUDING AUTOMOBILE INSURANCE AND WORKMEN'S COMPENSATION).

DID PATIENT'S WORK CAUSE THIS CONDITION? ☐ YES ☐ NO	HAS A CLAIM BEEN FILED WITH THE WORKMEN'S COMPENSATION CARRIER? ☐ YES ☐ NO	FIRST DAY UNABLE TO WORK DATE HOUR ☐ A.M. ☐ P.M.	IF YOU HAVE RETURNED TO WORK, GIVE DATE OF RETURN

IF CLAIM IS FOR AN INJURY COMPLETE THIS SECTION

DATE OF INJUIRY	TIME ☐ A.M. ☐ P.M.	WAS PATIENT AT WORK WHEN INJURED? ☐ YES ☐ NO	IF YES, FOR WHOM?

HOW DID INJURY HAPPEN?

WHERE WAS THE PATIENT WHEN INJURED?

"I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE ANY PESON OR INSTITUTION PROVIDING CARE OR SERVICES, OR ANY ORGANIZATION IN POSSESSION OF INSURANCE OR BENEFIT INFORMATION, TO RELEASE ANY AND ALL INFORMATION PERTAINING TO THE CARE OR BENEFITS PROVIDED TO ME OR MY DEPENDENTS.

EMPLOYEE'S SIGNATURE **X** **SIGN HERE** DATE SIGNED

PART 2 ATTENDING PHYSICIANS STATEMENT

PHYSICIAN'S STATEMENT OF DISABILITY

1. PATIENT'S NAME	AGE	ADDRESS
2. DIAGNOSIS AND CONCURRENT CONDITIONS (OR I.C.D.A.)	NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE, IF ANY (Describe Fully)	
3. IS CONDITION DUE TO INJURY OR ILLNESS ARISING OUT OF EMPLOYMENT? ☐ < YES NO > ☐	4. IS CONDITION DUE TO PREGNANCY? ☐ < YES NO > ☐	APPROX. DATE PREGNANCY COMMENCED

5. HAS A CLAIM BEEN FILED WITH A WORKER'S COMPENSATION CARRIER? IF YES, PLEASE IDENTIFY
☐ < YES NO > ☐

6. GIVE DATES OF TREATMENTS	OFFICE	
	HOME	
	HOSPITAL (ADMISSION)	(DISCHARGE)

7. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ NO ☐ YES

8. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	9. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION
10. PATIENT WAS CONTINUOUSLY DISABLED (UNABLE TO WORK) ☐ < YES NO > ☐ FROM THRU	11. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

DESCRIBE COMPLICATIONS, IF ANY, PRECLUDING PATIENT FROM RETURNING TO REGULAR OCCUPATION

Date	Print or type Physician's name & degree	Signature (Attending Physician)

Street address	City or Town	State	Zip Code	Telephone

PART 3 EMPLOYERS STMNT

EMPLOYER MUST CERTIFY FOR DISABILITY

DATE EMPLOYED	WEEKLY SALARY	FIRST FULL DAY UNABLE TO WORK	DATE RESUMED WORK	DATE EXPECTED TO RESUME WORK

IS THIS DISABILITY THE RESULT OF OCCUPATIONAL DISEASE OR INJURY ARISING IN THE COURSE OF EMPLOYMENT? ☐ < YES NO > ☐

Company Name _____

Mailing Address _____ Telephone _____
STREET CITY STATE ZIP (AREA CODE) NUMBER

Dated _____ 19 ___ By _____ Title _____

5,000 12/05