D

ACTIVITY STATUS/ FUNCTIONAL IMPAIRMENT

16. Cardiac -- (If Applicable) Shows functional capacity (American Heart Association)
☐ Class 1 -- no limitation
☐ Class 2 -- slight limitation
☐ Class 3 -- marked limitation
☐ Class 4 -- complete limitation

Blood pressure: _____ Date taken: ___/___/___

17. Physical Impairment (*as defined in Federal Dictionary of Occupational Titles)

☐ Class 1 – No limitation of functional capacity; capable of **heavy work**. *No restrictions (0-10%)
☐ Class 2 – Medium **manual activity**. * (15-30%)
☐ Class 3 – Slight limitation of functional capacity, capable of **light work**. * (35-55%)
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (**sedentary**) activity. (60-70%)
☐ Class 5 – Severe limitation of functional capacity; incapable of minimum (**sedentary***) activity. (75-100%)

Remarks:

18. Mental/Nervous Impairment (If Applicable):
(a) Please define "stress" as it applies to this patient.
(b) How do stress and interpersonal relations affect patient's ability to function on job?

☐ Class 1 – Able to function under stress and engage in interpersonal relations. (No limitations)
☐ Class 2 – Able to function in most stress situations and engage in most interpersonal relations. (Slight limitation)
☐ Class 3 – Able to engage in only limited stress situations and in only limited interpersonal relations. (Moderate limitations)
☐ Class 4 – Unable to engage in stress situations or in interpersonal relations. (Marked limitations)
☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment. (Severe limitations)

Remarks:

19. Is the patient mentally competent to endorse checks and direct use of proceeds?

20. List the current job duties the patient is **UNABLE** to perform due to his disability.

E

DISABILITY

21. Dates of continuous total disability

From:

Through: ___/___/___ ___/___/___

22. When will Patient be able to return to work? *"Other work"* usually means any suitable occupation for which the patient is sufficiently qualified by reason of his experience, education or training.

REGULAR WORK: _____ Approx. Date

OTHER WORK: _____ Approx. Date

PART TIME WORK: _____ Approx. Date

23. If patient can return to other work, what type of work do you recommend?

24. Would vocational counseling and/or retraining be recommended?

25. Remarks:

I authorize the release of information pertaining to hospital confinement of this patient to Teamsters Life Insurance Company. A photocopy of this authorization shall be as valid as the original.

Physician's Name _____ (Print or Type) Signature _____ Degree _____

Date _____ Address _____ Phone # _____

Complete and return this form to:
Teamsters Life Insurance Trust Fund
Attention: Life Benefits

Teamsters Life Insurance Trust Fund
4160 Dublin Blvd., Suite 400
Dublin, CA 94568 (925) 833-7315

PROOF OF TOTAL DISABILITY
PHYSICIAN'S STATEMENT

Administered by:
Teamsters Life Insurance Trust Fund

Note: Claimant is to pay all necessary expenses of submitting proof of total disability.

I AUTHORIZATION TO OBTAIN INFORMATION - To be Completed by Patient

I AUTHORIZE any physician, dentist, medical practitioner, hospital, clinic, other medical or medically-related facility, insurance or reinsuring company or employer, having information available as to diagnosis, treatment and prognosis with respect to any physical, dental or mental condition and/or treatment of me and any other non-medical information of me to give to Teamsters Life or its legal representative, any and all such information. I UNDERSTAND the information obtained by use of the Authorization will be used by Teamsters Life for disability evaluation to determine eligibility for insurance and eligibility for benefits under an existing policy. Any information obtained will not be released by Teamsters Life to any person or organization EXCEPT in conjunction with claim verification audit or review by the policyholder or its representative or to reinsuring companies, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.
I KNOW that I may request to receive a copy of this Authorization.
I AGREE that a photocopy of this Authorization shall be as valid as the original.
I AGREE this Authorization shall be valid for three years from the date shown below.

Date _____ Patient's Name (Please Print) _____ Signature of Patient _____

Soc. Sec. No. _____ Policy No. _____

II MEDICAL INFORMATION ---A through E to be Completed by Attending Physician

Please carefully read the following paragraph and the attached Claimant's Statement completed by the patient before fully completing parts A through E of the Physician's Statement. "Total disability" or "totally disabled", as judicially defined, means disability which prevents the Covered Person from working in his community with reasonable continuity in his customary occupation or in any other occupation in which he might reasonably be expected to engage in view of his station, mental and physical capacity, age, education, training and experience.

PATIENT'S NAME | Date of Birth

A HISTORY

1. Date symptoms first appeared or accident happened: ___/___/___
2. Date patient first consulted you for this condition: ___/___/___
3. Date patient was last seen by you: ___/___/___
4. Is condition due to injury or sickness arising out of patient's employment? ☐ YES ☐ NO
5. Has patient ever had same or similar condition? ☐ YES ☐ NO If "YES," when and describe.
6. Is condition a result of accidental bodily injury? ☐ YES ☐ NO If "YES," when and describe.

B PRESENT CONDITION

7. Subjective Symptoms
8. Objective Findings: (Include results of tests, x-rays & EKG's)
9. Diagnosis and concurrent conditions: (Including complications, if any, and progress)

☐ Ambulatory ☐ Bed Certified ☐ Hospital Confined
☐ Improving ☐ Unimproved ☐ Retrogressing

C TREATMENT

10. Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other _____
11. Nature of Treatment (Including medications prescribed, if any)
12. Has claimant been hospital-confined? ☐ YES ☐ NO If "YES" give name and address of hospital and dates of confinement:
    _____
    _____
    Admitted: ___/___/___
    Discharged: ___/___/___
13. Has surgery been performed?
14. What further treatment is recommended?
15. List names of other physicians currently treating this patient.