PHOENIX, AZ SERVICE CENTER
2550 W Union Hills Dr., Suite 250
Phoenix, AZ 85027

SALT LAKE CITY, UT SERVICE CENTER
5223 S Ascension Way., Suite 200
Murray, UT 84123

UTAH–IDAHO TEAMSTERS SECURITY FUND

Administrator: Southwest Service Administrators, Inc.
Mailing Address:
P.O. Box 43110
Phoenix, AZ 85080-3110

Disability Fax Line: (602) 324-0553

Toll Free Customer Service: (855) 292-7954

WEEKLY TIME LOSS--DISABILITY INCOME CLAIM FORM

PART A EMPLOYEE'S STATEMENT *(MUST BE COMPLETED BY EMPLOYEE)*

1. EMPLOYEE NAME (PLEASE PRINT)	2. BIRTH DATE MO DAY YEAR	3. SOCIAL SECURITY NO. / /
4. ADDRESS ☐ CHECK HERE IF NEW ADDRESS CITY STATE ZIP		5. PHONE NO. ( )
6. EMPLOYER (Name of Company you work for)		
6a. ADDRESS CITY STATE ZIP		7. PHONE NO. ( )
8. IS THIS CLAIM FOR AN ACCIDENT? ☐ YES ☐ NO	8a. IF YES – WHERE DID IT HAPPEN?:	
9. WHEN? MO DAY YEAR	10. DID THIS ACCIDENT/INJURY OCCUR ON THE JOB? ☐ YES ☐ NO	
11. HAVE YOU APPLIED FOR FMLA WITH YOUR EMPLOYER? ☐ YES ☐ NO	11a. HAVE YOU FILED FOR UNEMPLOYMENT BENEFITS? ☐ YES ☐ NO	
12. WERE YOU HOSPITALIZED AT THE TIME OF YOUR ACCIDENT/INJURY? ☐ YES ☐ NO		

13. EMPLOYEE STATEMENT AND AUTHORIZATION TO RELEASE INFORMATION:

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning this disability. I will reimburse the fund for any overpayment made to me or in my behalf due to error on this form. I understand that it is a federal crime, punishable by fine or imprisonment, or both, to knowingly make false statements on this benefit claim form.

Employee Signature _____ Date _____

***** DISABILITY INCOME BENEFITS CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE *****

PART B HUMAN RESOURCE STATEMENT *(MUST BE COMPLETED BY EMPLOYER / HR DEPARTMENT)*

1. LAST DAY WORKED / /	2. DATE RETURNED TO WORK-**IF APPLICABLE:** Complete this section if the employee has returned to work. If beginning of disability please check "Unknown/NA": Date:_____/_____/_____ ☐ Unknown/NA	3. DID INJURY (**IF APPLICABLE**) OCCUR ON THE JOB? ☐ YES ☐ NO 3a. HAS THE EMPLOYEE FILED FOR FMLA FOR THIS DISABILITY? ☐ YES ☐ NO
4. SIGNATURE OF EMPLOYER		5. DATE
6. PRINTED NAME/CONTACT PHONE NUMBER ( )_____		7. TITLE

PART C PHYSICIAN'S STATEMENT OF DISABILITY *(MUST BE COMPLETED BY PHYSICIAN)*

1. PATIENT'S NAME: (PLEASE PRINT)		2. INSURED'S SOCIAL SECURITY NUMBER / /
3. ICD.10 CODE WITH DESCRIPTION		4. IF DIAGNOSIS IS PREGNANCY, PLEASE LIST DUE DATE
5. DATE PATIENT DISABLED FROM WORK	6. DATE PATIENT SHOULD BE ABLE (OR EXPECTED) TO RETURN TO WORK (REQUIRED)	7. DATE PATIENT RELEASED TO RETURN TO WORK:
8. DATES PATIENT WAS FIRST SEEN FOR THIS DISABILITY		
9. FEDERAL TAX ID NUMBER	10. PHONE NUMBER	11. FAX NUMBER
12. PHYSICIAN NAME (PRINT)	13. PHYSICIAN CREDENTIALS (PRINT)	14. DATE
15. PHYSICIAN'S ADDRESS		16. PHYSICIAN'S SIGNATURE