Alaska Teamster-Employer Welfare Trust

Statement of Claim for Weekly Disability Benefits

Part One: To be Completed by Employee

Employee Name

Mailing Address

City

State

Zip Code

Medical ID #

Date of Birth

Date you were first unable to work

Was disability to an accident? ☐ Yes ☐ No

Is condition work related? ☐ Yes ☐ No

**If YES, give date of accident and a brief explanation

Employee Signature

Date

Part Two: Attending Physicians Statement

Nature of illness or injury

Is condition work related? ☐ Yes ☐ No

Date of first treatment

Date of most recent treatment

Date of next office treatment

The patient has been continuously disabled (unable to work) from

to

If still disabled, when should the patient be able to return to work?

Physician's Signature

Date

Mailing Address

Telephone

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