



Schrafft's City Center, 529 Main Street, Suite 209 • Charlestown, MA 02129
Local phone: 617-241-9220 • In MA: 800-442-9939 • Outside MA: 800-225-6135
Fax: 617-241-8168 • Website: <http://www.teamstercare.com>

POSSIBLE THIRD PARTY CLAIM REQUEST FOR ADDITIONAL INFORMATION

Please advise if you have any type of third party claim filed regarding the incident listed on the weekly disability claim you submitted.

PLEASE COMPLETE AND RETURN TO TEAMSTERS CARE MEMBER SERVICES

Member Name _____

Last Four Digits of Social Security No. _____

Date of Incident: _____

1. Do you have a workers' compensation (WC) claim, a motor vehicle claim, a lawsuit or any type of insurance claim filed regarding this incident?

Yes ☐ WC Claim ____ Insurance Claim ____ Lawsuit ____ No ☐

If yes, list the insurance company involved: _____

Insurance Company Name & Address _____

Insurance Company Adjustor and Phone Number _____

Claim No. _____

If you have retained an attorney, please list your attorney information:

Name, Address & Phone No. of Attorney: _____

2. Have you received any workers' compensation payments regarding this incident?

Yes ☐ No ☐

If yes, list starting date of workers' compensation payments: _____

List ending date of workers' compensation payment: _____

Member Signature _____

Date Signed _____

