TEAMCARE® - A CENTRAL STATES HEALTH PLAN
NOTICE OF CLAIM

PARTICIPANT'S LOCAL NO.: _____ DATE: _____

In order to apply for **DEATH** and **ACCIDENTAL DEATH BENEFITS**, please complete this form and follow the instructions set forth below:

(Please type or print)

1	Participant's Name: (Last) (First) (MI)	Date of Birth:	Participant ID Number:
	Participant's Address (No. Street, City, State, Zip Code): •	Participant's Phone:	Occupation:

2	Name and Address of Employer:	Date Last Worked:

3	Was Participant on Medicare? ☐ Yes ☐ No **If Yes, send us a copy of your Medicare Card**

4	If the Participant's death certificate indicates divorced, please give date:

5	Type of Claim (Check One)	☐ Participant Death ☐ Participant Accidental Death ☐ Dependent Spouse Death ☐ Dependent Child Death	☐ Participant Total & Permanent Disability (Under age 50 on date of disability) ☐ Participant Total & Permanent Disability (Ages 50 thru 59 on date of disability)

6	Name and Address of Applicant for Benefits: _____ _____ _____ (If more than one applicant, use back of form)	Telephone No.: _____ Relationship to Participant: _____

7

Please attach the indicated documents to this Notice of Claim

ALL DEATH CLAIMS MUST HAVE CERTIFIED DEATH CERTIFICATE

*Form is available from TeamCare by calling 800-TEAMCARE or visiting our website at MyTeamCare.org

FOR PARTICIPANT DEATH

Participant had Waiver of Premium: Claim No.: _____

Participant was on TPD: Claim No.: _____

FOR ACCIDENTAL DEATH

- Include police, autopsy and toxicology reports when available

FOR DEPENDENT SPOUSE OR CHILD DEATH

- Copy of Birth Certificate for Child Death
- Copy of Marriage Certificate for Spouse Death

Name: _____ Relationship to Participant: _____

FOR PARTICIPANT TOTAL & PERMANENT DISABILITY / WAIVER OF PREMIUM

- Claimant's/Employer's Statement Sections 1 and 2*
- Doctor's Statement Section 3*
- Copy of Social Security Award
- Copy of Birth Certificate or Driver's License
- Completed and Signed Health and Welfare Designation of Beneficiary Form*

Date of Disability: _____

8	Mail this completed Notice of Claim with the requested Documents to: **TEAMCARE - A CENTRAL STATES HEALTH PLAN** **LIFE INSURANCE DEPARTMENT** **PO BOX 5116** **DES PLAINES, IL 60017-5116**	_____ Signature of Applicant(s)