Northwest Insulation Workers Welfare Trust

FUND 55

WEEKLY DISABILITY CLAIM FORM

This form is for: ☐ Initial request for benefits ☐ Supplemental information on active disability claim
☐ Check here if your address is new

SECTION A	TO BE COMPLETED BY THE EMPLOYEE				
EMPLOYEE NAME		☐ MALE ☐ FEMALE	DATE OF BIRTH		SOCIAL SECURITY NO. or ID NUMBER
HOME ADDRESS	CITY		STATE	ZIP	TELEPHONE NO. EMAIL:

A. Description of accident or injury____________________

B. Date of accident or date of injury____________________

C. Were you at work? ☐ Yes ☐ No Have you or will you file for Workers' Compensation Benefits? ☐ Yes ☐ No

D. Name of your doctor____________________

E. Name and address of hospital ____________________

F. Date entered hospital____________________ Date discharged____________________

G. Are you retired? ☐ Yes ☐ No
If no, anticipated date of retirement:____________________ If yes, when: ____________________

H. Are you entitled to receive Federal Social Security Disability Benefits for any portion of this disability? Yes____ No____. If yes, date Federal Social Security Disability benefits began:__________ Date benefits will end:__________

"I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Insurance Company, Employer, Health Plan Administrator or Local Union Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable including disability or employment related information concerning this claim to Welfare & Pension Administration Service, Inc. or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request."

I certify that my accident injury did not arise as a result of a plan exclusion as listed in the Benefit Description brochure.

SIGN HERE► ____________________ ____________________

EMPLOYEE SIGNATURE DATE SIGNED

SECTION B	TO BE COMPLETED BY THE EMPLOYER
Employer:	Local Union No.
Job Classification: ____________________	Weekly Earnings: $____________________
Date employee last worked:	
Date employee returned to work, if applicable:	

SIGN HERE► ____________________ ____________________

AUTHORIZED REPRESENTATIVE DATE SIGNED

SECTION C	TO BE COMPLETED BY ATTENDING PHYSICIAN
PATIENT'S NAME:	AGE:
DIAGNOSIS (ICD CODE(S) ONLY):	IF HOSPITALIZED FOR THIS CONDITION GIVE DATE OF ADMIT:
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO	PREGNANCY? IF YES, APPROXIMATE DATE OF DELIVERY: ☐ YES ☐ NO
IS CONDITION RESULT OF INJURY, ACCIDENT OR SICKNESS? ☐ INJURY ☐ ACCIDENT ☐ SICKNESS	
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED:	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION:
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO IF "YES", WHEN & DESCRIBE:	IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO
PATIENT WAS CONTINUOUSLY UNABLE TO WORK FROM: TO:	LAST DATE WORKED:
IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:	DATE EMPLOYEE RETURNED TO WORK:

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE	TELEPHONE
		X		

STREET ADDRESS	CITY – STATE – ZIP CODE

PROCEDURE FOR FILING A CLAIM

1. Complete the Employee Section.

2. Have your employer complete the Employer Section.

3. Have your Doctor complete the Attending Physician's Section for each disability.

4. Mail completed claim form to:

Northwest Insulation Workers Welfare Trust
PO Box 34564
Seattle, WA 98124-1564

Or email to claimstatus@wpas-inc.com