IMPACT Off-the-Job Accident Plan

PLAN 76

WEEKLY TIME LOSS CLAIM FORM

Administered by

Welfare & Pension Administration Service, Inc. • PO Box 34687 • Seattle, WA 98124-1687
Phone (800) 331-6158 • Fax (206) 441-9110

☐ 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	BOOK NO.	SOCIAL SECURITY NO.
HOME ADDRESS CITY STATE ZIP				TELEPHONE NO.

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: _____

"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."

SIGN HERE► _____ _____
EMPLOYEE SIGNATURE DATE SIGNED

SECTION B	TO BE COMPLETED BY THE LOCAL UNION	
Employer:	Local Union No.	RAB:
Job Classification: ☐ Apprentice ☐ Journeyman ☐ Foreman ☐ General Foreman ☐ Other _____		Basic 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 (ICD9 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 X	DEGREE	TELEPHONE
STREET ADDRESS	CITY – STATE – ZIP CODE	

SEE REVERSE SIDE FOR INSTRUCTIONS

PROCEDURE FOR FILING A CLAIM

1. Complete the Employee Information in 'Section A'

2. Have your Local Union complete 'Section B'

3. Have your Doctor complete the Attending Physician's Statement in 'Section C', for each disability

4. Mail completed claim form to:

IMPACT Off-the-Job Accident Plan
PO Box 34687
Seattle, WA 98124-1687

Phone: (206) 441-7574 or (800) 331-6158
Fax: (206) 441-9110

or Scan and Email to: claimstatus@wpas-inc.com