IMPACT Off-the-Job Accident Plan

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 ☐ MALE
☐ FEMALE **EMPLOYEE NAME** DATE OF BIRTH BOOK NO. SOCIAL SECURITY NO. HOME ADDRESS CITY STATE TELEPHONE NO. ZIP Description of accident or injury A. Date of accident or date of injury__ В. ☐ No ☐ Yes ☐ No ☐ Yes Have you or will you file for Workers' Compensation Benefits? Were you at work? D. Name of your doctor_ E. Name and address of hospital Date entered hospital_ Date discharged_____ □ No Are you retired? ☐ Yes 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 TO BE COMPLETED BY THE LOCAL UNION **SECTION B** Local Union No. RAB: Employer: 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 TO BE COMPLETED BY ATTENDING PHYSICIAN

SECTION C 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 PREGNANCY? IF YES, APPROXIMATE DATE OF DELIVERY: EMPLOYMENT? † YES † NO ☐ INJURY ☐ ACCIDENT ☐ SICKNESS IS CONDITION RESULT OF INJURY, ACCIDENT OR SICKNESS? DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED: DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION: IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? IF "YES", WHEN & DESCRIBE: † NO YES PATIENT WAS CONTINUOUSLY UNABLE TO WORK LAST DATE WORKED: IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK: DATE EMPLOYEE RETURNED TO WORK: PHYSICIAN'S NAME (PRINT) SIGNATURE DEGREE TELEPHONE DATE X STREET ADDRESS CITY - STATE - 7IP CODE

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