PLAN 15T

Northwest Ironworkers Health and Security Fund

WEEKLY DISABILITY BENEFITS CLAIM FORM

Administered by Welfare & Pension Administration Service, Inc. • PO Box 34464 • Seattle, WA 98124-1464 • (866) 986-1515 ☐ Initial request for benefits ☐ Supplemental information on active disability claim This form is for: ☐ Check here if your address is new TO BE COMPLETED BY THE EMPLOYEE EMPLOYEE NAME ☐ MALE DATE OF BIRTH SOCIAL SECURITY # or ID # ☐ FEMALE HOME ADDRESS TELEPHONE NO. CITY STATE ZIP Description of accident or sickness_ (If accident or injury, you must have the Local Union complete the section below.) Date of accident or beginning of sickness_ Were you at work? ☐ Yes ☐ No Have you or will you file for Workers' Compensation Benefits? ☐ Yes ☐ No C., Name of doctor Name and address of hospital ___ Date entered hospital Date discharged ☐ Yes \square No Are you retired? If no, anticipated date of retirement: If yes, when: "I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Insurance Company, Employer or 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 the Plan Administrator 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 (FOR ACCIDENT CLAIMS ONLY) TO BE COMPLETED BY THE LOCAL UNION Employer: Job Classification: ☐ Apprentice ☐ Journeyman ☐ Foreman ☐ General Foreman 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 PATIENT'S NAME: AGE: DIAGNOSIS (ICD10 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: \square NO ☐YES EMPLOYMENT? ☐ YES \square NO ☐ SICKNESS ☐ INJURY ☐ ACCIDENT IS CONDITION RESULT OF INJURY, ACCIDENT OR SICKNESS? DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION: DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED: HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? □NO IF "YES", WHEN & DESCRIBE: PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (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 DATE DEGREE **TELEPHONE**

CITY - STATE - ZIP CODE

STREET ADDRESS

PROCEDURE FOR FILING A CLAIM

- 1. Complete the Employee section.
- 2. Have your employer complete Employer section.
- 3. Have your doctor complete the Attending Physician's Section for each disability.
- 4. Mail completed claim form to:

Northwest Ironworkers Health and Security Fund PO Box 34464 Seattle, WA 98124-1464

Phone: (206) 441-7226 or (866) 986-1515