IRON WORKERS TRUST FUND LOCAL NO.5

TIME LOSS CLAIM FORM

Administered by

Welfare & Pension Administration Service, Inc. • PO Box 34945 • Seattle, WA 98124-1945 • (877) 367-0541

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

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

A. Description of accident or sickness_____

(If accident or injury, you must have the Local Union complete the section below.)

B. Date of accident or beginning of sickness_____

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

D. Name of 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 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:	Area:
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 EMPLOYMENT? ☐ YES ☐ NO	PREGNANCY? IF YES, APPROXIMATE DATE OF DELIVERY: ☐ YES ☐ NO
IS CONDITION RESULT OF INJURY, ACCIDENT OR SICKNESS? ☐ SICKNESS ☐ INJURY ☐ ACCIDENT	
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 TOTALLY DISABLED (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

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SEE REVERSE SIDE FOR INSTRUCTIONS

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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:

Iron Workers Trust Fund Local No. 5
PO Box 34945
Seattle, WA 98124-1945

Phone: (206) 441-7574 or (877) 367-0541