AGC IUOE Local 701 Health & Welfare Trust Fund

TIME LOSS – SICK PAY CLAIM FORM

Physical Address 15 - 82nd Drive Suite 110 Gladstone, Oregon 97027 • Mailing Address PO Box 34203 Seattle, WA 98124
Phone (866) 697-5750 or (503) 657-9740 • Fax (503) 657-9737 • Website www.agc-iuoe701trusts.com
Administered by
Welfare & Pension Administration Service, Inc.

This form is for: Initial request for benefits Supplemental information on active disability claim

TO BE COMPLETED BY THE EMPLOYEE			
Employee Name	☐ Male ☐ Female	Date of Birth	Social Security Number
Home Address City ST Zip			Telephone No.

Description of accident or sickness: _____

Date of accident or beginning sickness: _____ Were you at work? Yes No

Have you or will you file for Workers Compensation? Yes No

Name and address of attending physician: _____

Date entered hospital: _____ Date discharged: _____

Name of Hospital: _____

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 _____ **DATE** _____
EMPLOYEE SIGNATURE

TO BE COMPLETED BY ATTENDING PHYSICIAN

Patient's Name: Age:	
Diagnosis and concurrent conditions: (if diagnosis code other than IDCA used, give name) If hospitalized for this condition, Give date of admit:	
Is condition due to injury or sickness arising out of patient's Employment? Yes No	Is condition due to Pregnancy? Yes No If yes, approximate date pregnancy commenced. Date:
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
Physician's Name (Print) Degree Telephone Number	
Physician's Signature Date	
Physician's Address (street, city, state, zip)	

PROCEDURE FOR FILING A CLAIM

1. Complete the Employee Portion.

2. Have your doctor complete the Attending Physician's Section for each disability.

3. Mail completed claim form to:

AGC IUOE Local 701 Health & Welfare Trust Fund
PO BOX 34687
Seattle, WA 98124-1687

Phone: (866) 697-5750