AGC IUOE Local 701 Health & Welfare Trust Fund

TIME LOSS – SICK PAY CLAIM FORM

Administered by
Welfare & Pension Administration Service, Inc. • PO Box 34687 • Seattle, WA 98124-1687 • (866) 697-5750

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

TO BE COMPLETED BY THE EMPLOYEE

PART 1 - EMPLOYEE INFORMATION

EMPLOYEE'S NAME - First Initial Last	☐Male ☐ Female	DATE OF BIRTH	SOCIAL SECURITY NUMBER

HOME ADDRESS STREET	CITY	STATE	ZIP	PHONE

EMAIL ADDRESS

PART 2 - ACCIDENT/INJURY INFORMATION

WAS CARE REQUIRED BECAUSE OF AN INJURY? ☐YES ☐NO DID ACCIDENT OCCUR WHILE AT WORK? ☐ YES ☐ NO

DATE INJURED _____ DESCRIBE HOW INJURY OCCURRED: _____

HAS CLAIM BEEN FILED WITH LABOR AND INDUSTRIES? ☐YES ☐NO IF "YES", GIVE CLAIM NUMBER _____

LAST DAY WORKED _____ DATE RETURNED TO WORK _____

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 ICD10 USED, GIVE NAME) IF HOSPITALIZED FOR THIS CONDITION, GIVE DATE OF ADMIT:	
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYEMENT? ☐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 all applicable sections of the "Employee Statement." Failure to properly complete the "Employee Statement" may result in a delay in processing your claim.
2. Have your doctor complete the Attending Physician's Section for each disability.
3. **Mail completed form:**

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PO BOX 34687
Seattle, WA 98124-1687

Phone: (866) 697-5750

Direct Deposit Enrollment Form

LAST NAME	FIRST NAME	LAST 4 NUMBERS OF SOC. SEC. NO.
HOME ADDRESS INCLUDING CITY - STATE - ZIP		
PHONE NUMBER.	EMAIL ADDRESS	
BANK NAME	BANK ACCOUNT TYPE ☐CHECKING ☐SAVINGS	
BANK ROUTING NO.	BANK ACCOUNT NO.	

Important
Attach Voided Check

If you wish to have your weekly disability benefit sent directly to your bank, please complete the above information along with the following:

1. A voided, check, with your name and address information pre-printed by the bank.

Here is how direct deposit works:

- We receive your signed and dated weekly disability claim form along with your voided check.
- We enter your account number, account type (checking or savings), and the routing number of your bank into our system.
- Assuming all necessary documents are received, your weekly disability benefit will be deposited directly into your account.

By signing this form, I authorize my weekly disability benefit to be deposited into the financial institution above. I confirm that I am an authorized signer on this account and agree to notify AGC Local 701 Health & Welfare Trust Fund in advance if this account is closed.

SIGN HERE _____ **DATE** _____

EMPLOYEE SIGNATURE