WEEKLY INCOME / DISABILITY WAIVER APPLICATION

RETURN THIS FORM TO:

COMPLETE AS FOLLOWS:

PART I	**EMPLOYEE**
PART 2 & 4	**EMPLOYER**
PART 3	**PHYSICIAN**

WASHINGTON TEAMSTERS WELFARE TRUST

2323 EASTLAKE AVE EAST SEATTLE, WASHINGTON 98102-3393

CLAIMS/BENEFITS ONLY (206) 726-3277 Or 1-800-458-3053 ELIGIBILITY/OTHER (206) 726-3344 FAX (206) 726-3229

PART I – TO BE COMPLETED BY THE EMPLOYEE

EMPLOYEE'S NAME (LAST) (FIRST) (INITIAL)

NAME OF COMPANY YOU WORK FOR

ADDRESS

DATE EMPLOYED

EMPLOYEE'S DATE OF BIRTH

☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED

CITY, STATE, ZIP CODE

SOCIAL. SECURITY NO.

LOCAL UNION NO.

HOME TELEPHONE NO.

DID YOUR WORK CAUSE THIS CONDITION? ☐ YES ☐ NO

HAS A CLAIM BEEN FILED WITH THE WORKER'S COMPENSATION CARRIER? ☐YES ☐ NO
STATE CASE NO.:

FIRST DAY UNABLE TO WORK
DATE__________ HOUR________
☐ A.M.
☐ P.M.

IF YOU HAVE RETURNED TO WORK, GIVE DATE OF RETURN

ARE YOU ENGAGED IN ANY OCCUPATION FOR WAGE OR PROFIT DURING THIS DISABILITY (I.E. SELF-EMPLOYED, OWN YOUR OWN BUSINESS, WORKING PART-TIME AT A DIFFERENT EMPLOYER)? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE NATURE OF THAT WORK.
HOW MANY HOURS PER WEEK: ________________ WEEKLY INCOME: $__________

IF CLAIM IS FOR AN INJURY, YOU MUST COMPLETE THIS SECTION

DATE OF INJURY

TIME ☐A.M. ☐P.M.

WERE YOU AT WORK WHEN INJURED? ☐ YES ☐ NO
IF YES, FOR WHOM?

HOW DID INJURY HAPPEN

WHERE WERE YOU WHEN INJURED?

NATURE OF INJURY

I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE ANY PERSON OR INSTITUTION PROVIDING CARE OR SERVICE, OR ANY ORGANIZATION IN POSSESSION OF INSURANCE OR BENEFIT INFORMATION TO RELEASE ANY AND ALL INFORMATION PERTAINING TO THE CARE OR BENEFITS PROVIDED TO ME.

EMPLOYEE'S SIGNATURE

X ← SIGN HERE

DATE SIGNED

PART 2 – TO BE COMPLETED BY THE EMPLOYER

DATE EMPLOYED	FIRST FULL DAY UNABLE TO WORK	DATE LAST WORKED	DATE RESUMED WORK	DATE EXPECTED TO RESUME WORK

IS THIS DISABILITY THE RESULT OF OCCUPATIONAL DISEASE OR INJURY ARISING IN THE COURSE OF EMPLOYMENT? ☐ YES ☐ NO

IF YES, GIVE DATE OF ONSET OR INJURY

HAS EMPLOYEE RETURNED TO WORK ON A PART-TIME OR LIGHT DUTY BASIS? ☐ YES ☐ NO

IF YES, PLEASE COMPLETE PART 4 ON THE BACK OF THIS FORM

EMPLOYER'S SIGNATURE

← SIGN HERE

TELEPHONE NO.

DATE SIGNED

PRINT OR TYPE NAME OF PERSON SIGNING

EMPLOYER ADDRESS

PART 3 - TO BE COMPLETED BY ATTENDING PHYSICIAN

PATIENT NAME

AGE

IS CONDITION DUE TO INJURY OR ILLNESS ARISING OUT OF EMPLOYMENT?
☐ YES ☐ NO

IF YES, PLEASE PROVIDE STATE CASE NUMBER AND INDICATE RELATED DIAGNOSES.
STATE CASE NO.:________________
DIAGNOSES:

DIAGNOSIS AND CONCURRENT CONDITIONS (OR ICD9)

IS CONDITION DUE TO PREGNANCY? ☐ YES ☐ NO
EXPECTED DATE OF DELIVERY

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

PATIENT WAS CONTINUOUSLY DISABLED (UNABLE TO WORK)
☐ YES ☐ NO
FROM THRU

IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK

DATE(S) PATIENT HAS BEEN SEEN FOR THIS CONDITION

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐YES ☐ NO

PRINT OR TYPE PHYSICIAN'S NAME AND DEGREE

SOC. SEC. NO. OR TAX ID

STREET ADDRESS CITY STATE ZIP CODE

SIGNATURE (ATTENDING PHYSICIAN)

← SIGN HERE

TELEPHONE NO.

DATE SIGNED

COMPLETE AS FOLLOWS:	
PART 1	EMPLOYEE
PART 2 & 4	EMPLOYER
PART 3	PHYSICIAN

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PART 4 - TO BE COMPLETED BY EMPLOYER

COMPLETE THIS SECTION IF DISABILITY IS NOT WORK RELATED AND THE EMPLOYEE HAS RETURNED TO PART-TIME OR LIGHT-DUTY WORK.

IF THE EMPLOYEE IS UNABLE TO RETURN TO NORMAL DUTIES ON A FULL-TIME BASIS DUE TO WORK RESTRICTIONS BY THE PHYSICIAN BUT HAS RETURNED TO PART-TIME OR LIGHT-DUTY WORK, THE EMPLOYEE'S TIME LOSS BENEFITS ARE LIMITED TO THE LESSER OF THE AMOUNT OF BENEFITS NEGOTIATED IN THE COLLECTIVE BARGAINING AGREEMENT OR THE DIFFERENCE BETWEEN THE EMPLOYEE'S BASE WAGE (STRAIGHT-TIME PAY) BEFORE THE DISABILITY AND ANY LIGHT DUTY, SICK LEAVE PAY OR PART-TIME REGULAR-DUTY WAGES. IT IS THE EMPLOYER'S RESPONSIBILITY TO NOTIFY THE TRUST OFFICE IF AN EMPLOYEE HAS RETURNED TO PART-TIME OR LIGHT-DUTY WORK BY SUBMITTING THE INFORMATION BELOW.

NUMBER OF STRAIGHT TIME HOURS WORKED WEEKLY PRIOR TO DISABILITY	STRAIGHT TIME WAGE AT TIME OF DISABILITY (BEFORE WITHHOLDING)
_______HOURS PER WEEK	$_____________ PER HOUR $________________ PER WEEK

HOW MANY HOURS PER WEEK IS EMPLOYEE WORKING PART TIME OR LIGHT DUTY AND HOW MUCH SICK LEAVE PAY IS EMPLOYEE RECEIVING? (COMPLETE DETAILS BELOW)

FROM MONDAY	THRU SUNDAY	HOURS WORKED (INCL. HOLIDAY)	HOURLY RATE	PAID SICK LEAVE HOURS	HOURLY RATE	TOTAL WEEKLY PAY (EXCLUDING VACATION PAY)
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EMPLOYER SIGNATURE	TELEPHONE NUMBER
PRINT OR TYPE NAME OF PERSON SIGNING	DATE SIGNED