WEEKLY INCOME / DISABILITY WAIVER APPLICATION

COMPLETE AS FOLLOWS:

PART I **EMPLOYEE**
PART II **EMPLOYER**
PART III **PHYSICIAN**

RETURN THIS FORM TO:

WESTERN TEAMSTERS WELFARE TRUST

NORTHWEST ADMINISTRATORS, INC. PO BOX 20231 SEATTLE, WASHINGTON 98102-3393
HW-Timeloss-Adjustors@nwadmin.com
CLAIMS / BENEFITS: (206) 726-3235 Or 1-800-872-5439 ELIGIBILITY / OTHER: (206) 329-4900 FAX: (206) 926-2773

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 #:

FIRST DAY UNABLE TO WORK
DATE _____ HOUR _____
☐ A.M. ☐ P.M.

IF YOU HAVE RETURNED TO WORK, GIVE DATE OF RETURN

CIRCLE YOUR REGULARLY SCHEDULED DAYS OF WORK
SUN MON TUES WED THUR FRI SAT

IF HOSPITALIZED, NAME OF HOSPTIAL

DATE ADMITTED

DATE RELEASED

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 II - TO BE COMPLETED BY THE EMPLOYER

DATE EMPLOYED

LAST DAY WORKED

FIRST FULL DAY UNABLE TO WORK

DATE RESUMED OR EXPECTED TO RESUME WORK

HAS THE EMPLOYEE RETURNED TO WORK ON A MODIFIED OR LIGHT DUTY BASIS? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE DATES HE/SHE HAS WORKED MODIFIED OR LIGHT DUTY:

IF NO, IS THE COMPANY ABLE TO ACCOMMODATE LIGHT DUTY WORK FOR THIS EMPLOYEE?

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

EMPLOYER'S SIGNATURE

TELEPHONE NO.

DATE SIGNED

PRINT OR TYPE NAME OF PERSON SIGNING

EMAIL

PART III - TO BE COMPLETED BY ATTENDING PHYSICIAN

PATIENT NAME

AGE

IS CONDITION DUE TO INJURY OR ILLNESS ARISING OUT OF EMPLOYMENT?
☐ YES ☐ NO IF YES, STATE CASE #:

ICD-10 DIAGNOSIS AND CONCURRENT CONDITIONS

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:

IF INPATIENT, DATES OF HOSPITALIZATION: ADMIT: DISCHARGE:

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

HOW LONG WAS OR WILL PATIENT BE TOTALLY DISABLED (UNABLE TO WORK)?
FROM THRU

DATE(S) PATIENT HAS BEEN SEEN FOR THIS CONDITION

HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED?
FROM THRU

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

PRINT PHYSICIAN'S NAME AND DEGREE

SOC. SEC. NO. OR TAX ID

STREET ADDRESS CITY STATE ZIP CODE

SIGNATURE (ATTENDING PHYSICIAN)
X

DATE

TELEPHONE NO.: FAX NO.: