# WEEKLY INCOME / DISABILITY WAIVER APPLICATION

COMPLETE AS FOLLOWS:

PART I EMPLOYEE
PART 2 & 4 EMPLOYER
PART 3 PHYSICIAN

*RETURN THIS FORM TO:*

## WASHINGTON TEAMSTERS WELFARE TRUST

PO BOX 20231 SEATTLE, WASHINGTON 98102

CLAIMS/BENEFITS ONLY (206) 726-3277 OR 1-800-458-3053
ELIGIBILITY/OTHER (206) 726-3344 ~~FAX (206) 926-2675~~ OR FAX (206) 926-2672

## 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 |
|---|---|---|---|

CIRCLE YOUR REGULARLY SCHEDULED DAYS OF WORK

SUN MON TUES WED THUR FRI SAT

DID YOUR CONDITION REQUIRE YOU TO UNDERGO OR SCHEDULE SURGERY?
IF YES, GIVE SURGERY DATE:

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 | |

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## 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: |
|---|---|
| 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 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 |
| DID THE PATIENT'S CONDITION REQUIRE SURGERY? ☐ YES ☐ NO | DATE OF SURGERY: |

| PRINT OR TYPE PHYSICIAN'S NAME AND DEGREE | SOC. SEC. NO. OR TAX ID |
|---|---|
| | |

| STREET ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| TELEPHONE NO. | FAX NO. |
|---|---|
| | |

| SIGNATURE (ATTENDING PHYSICIAN) SIGN HERE ➔ | DATE SIGNED |
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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 _____ HOURS PER WEEK | STRAIGHT TIME WAGE AT TIME OF DISABILITY (BEFORE WITHHOLDING) $_____ 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** (m/d/yy) | THRU **SUNDAY** (m/d/yy) | 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 |
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| PRINT OR TYPE NAME OF PERSON SIGNING | DATE SIGNED |
|---|---|
| | |