IMPACT Maternity Benefits Plan

PLAN 76

For Members of the International Association of Ironworkers

WEEKLY TIME LOSS CLAIM FORM

Administered by

Welfare & Pension Administration Service, Inc. • PO Box 34687 • Seattle, WA 98124-1687 Phone (800) 331-6158 • Fax (206) 441-9110

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

☐ Check here if your address is new

SECTION A	TO BE COMPLETED BY THE IRONWORKER			
IRONWORKER NAME	DATE OF BIRTH	BOOK NO.	SOCIAL SECURITY NO.	
HOME ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.
EMAIL				

A. Expected Birth Date: _____

B. Are you requesting Leave prior to your expected birth date? ☐ Yes ☐ No

C. If Yes, requested Leave date: _____

D. Reason for requested leave: _____

E. Name of your doctor: _____

If you are hospitalized or have delivered:

F. Name and address of hospital/Care Facility _____

F. Date entered hospital/Care Facility (*if applicable*)_____Date Discharged_____

G. Delivery Date (*if applicable)* _____

"I hereby authorize Physician, Hospital, Pharmacy, Insurance Company, Employer, Health Plan Administrator or Local Union Organization to release any information regarding the medical, mental, treatment or benefits payable including disability or employment related information concerning this claim to Welfare & Pension Administration Service, Inc. 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► _____

IRONWORKER SIGNATURE DATE SIGNED

SECTION B	TO BE COMPLETED BY THE LOCAL UNION
Employer:_____Local Union No._____RAB: _____	
Job Classification: ☐ Apprentice ☐ Journeyman ☐ Foreman ☐ General Foreman ☐ Other _____ Gross Hourly Wage/ Earnings: $_____	
Date Ironworker last worked:	
Date Ironworker returned to work, if applicable:	
Was the Ironworker a member on the date of leave or requested leave? ☐ Yes ☐ No	

SIGN HERE► _____

AUTHORIZED UNION REPRESENTATIVE DATE SIGNED

SECTION C	TO BE COMPLETED BY ATTENDING PHYSICIAN	
PATIENT'S NAME:		AGE:
DIAGNOSIS (ICD10):	IF HOSPITALIZED, GIVE DATE OF ADMIT:	
APPROXIMATE DELIVERY / BIRTH DATE:		
IS LEAVE REQUEST RESULT OF INJURY/ACCIDENT OR SICKNESS/ILLNESS? ☐ INJURY/ACCIDENT ☐ SICKNESS/ILLNESS		
THIS WILL CERTIFY PATIENT IS/WAS CONTINUOUSLY UNABLE TO WORK DUE TO PHYSICIAL LIMITATIONS ARISING FROM PREGNANCY: FROM: TO:		LAST DATE WORKED:
IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:		DATE IRONWORKER RETURNED TO WORK:
PHYSICIAN'S NAME (PRINT)	DEGREE	TELEPHONE
STREET ADDRESS		CITY – STATE – ZIP CODE

SIGN HERE► _____ _____

PHYSICIAN SIGNATURE DATE SIGNED

PROCEDURE FOR FILING A MATERNITY CLAIM

1. Complete the Ironworker Information in 'Section A'
2. Have your Local Union complete 'Section B'
3. Have your Doctor complete the Attending Physician's Statement in 'Section C'
4. Mail completed claim form to:

IMPACT Maternity Benefit Plan
PO Box 34687
Seattle, WA 98124-1687

Fax: 206-441-9110

or Scan and Email to: claimstatus@wpas-inc.com

Questions? Call Phone: (206) 441-7574 or (800) 331-6158