

# IMPACT Off-the-Job Accident Plan

PLAN 76

## 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

Initial request for benefits  Supplemental information on active disability claim

Check here if your address is new

SECTION A TO BE COMPLETED BY THE EMPLOYEE				
EMPLOYEE NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	BOOK NO.	SOCIAL SECURITY NO.
HOME ADDRESS	CITY	STATE	ZIP	TELEPHONE NO.

- A. Description of accident or injury \_\_\_\_\_
- B. Date of accident or date of injury \_\_\_\_\_
- C. Were you at work?  Yes  No Have you or will you file for Workers' Compensation Benefits?  Yes  No
- D. Name of your doctor \_\_\_\_\_
- E. Name and address of hospital \_\_\_\_\_
- F. Date entered hospital \_\_\_\_\_ Date discharged \_\_\_\_\_
- G. Are you retired?  Yes  No  
If no, anticipated date of retirement: \_\_\_\_\_ If yes, when: \_\_\_\_\_

"I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Insurance Company, Employer, Health Plan Administrator or Local Union 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 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 ►** \_\_\_\_\_  
EMPLOYEE SIGNATURE DATE SIGNED

SECTION B TO BE COMPLETED BY THE LOCAL UNION	
Employer:	Local Union No. RAB:
Job Classification:	
<input type="checkbox"/> Apprentice <input type="checkbox"/> Journeyman <input type="checkbox"/> Foreman <input type="checkbox"/> General Foreman <input type="checkbox"/> Other _____	Basic Weekly Earnings: \$ _____
Date employee last worked:	
Date employee returned to work, if applicable:	

**SIGN HERE ►** \_\_\_\_\_  
AUTHORIZED REPRESENTATIVE DATE SIGNED

SECTION C TO BE COMPLETED BY ATTENDING PHYSICIAN				
PATIENT'S NAME:	AGE:			
DIAGNOSIS (ICD10 ONLY):	IF HOSPITALIZED FOR THIS CONDITION GIVE DATE OF ADMIT:			
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PREGNANCY? IF YES, APPROXIMATE DATE OF DELIVERY: <input type="checkbox"/> YES <input type="checkbox"/> NO			
IS CONDITION RESULT OF INJURY, ACCIDENT OR SICKNESS? <input type="checkbox"/> INJURY <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SICKNESS				
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED:	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION:			
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", WHEN & DESCRIBE:	IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO			
PATIENT WAS CONTINUOUSLY 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:			
DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE	TELEPHONE
STREET ADDRESS		CITY - STATE - ZIP CODE		

## **PROCEDURE FOR FILING A CLAIM**

1. Complete the Employee 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', for each disability
4. Mail completed claim form to:

**IMPACT Off-the-Job Accident Plan  
PO Box 34687  
Seattle, WA 98124-1687**

**Phone: (206) 441-7574 or (800) 331-6158  
Fax: (206) 441-9110**

**or Scan and Email to: [claimstatus@wpas-inc.com](mailto:claimstatus@wpas-inc.com)**