

IMPACT Off-the-Job Accident Plan

PLAN 76

WEEKLY TIME LOSS CLAIM FORM

PO Box 34687 • Seattle, WA 98124-1687 Phone (800) 331-6158 • Fax (206) 441-9110

Administered by Welfare & Pension Administration Service, Inc.

Initial request for benefits Supplemental information on active disability claim Check here if your address is new

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

- 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. WERE YOU UNDER THE INFLUENCE OF INTOXICANTS WHILE OPERATING A VEHICLE? YES NO
- E. NAME OF YOUR DOCTOR _____
- F. NAME AND ADDRESS OF HOSPITAL _____
- G. DATE ENTERED HOSPITAL _____ DATE DISCHARGED _____ IF YES, WHEN: _____
- H. ARE YOU RETIRED? YES NO IF NO, ANTICIPATED DATE OF RETIREMENT: _____
IF YES, WHEN: _____
- I. ARE YOU RECEIVING OR ENTITLED TO RECEIVE UNEMPLOYMENT BENEFITS? YES NO
- J. IF YES, WHAT IS/WAS YOUR LAST DATE OF WEEKLY UNEMPLOYMENT BENEFITS? _____ K. IF NO, DO YOU INTEND TO FILE A CLAIM FOR UNEMPLOYMENT BENEFITS? _____

"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 ▶ _____
IRONWORKER 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 _____	GROSS BASIC WEEKLY EARNINGS: \$ _____
DATE IRONWORKER LAST WORKED: _____	DATE IRONWORKER RETURNED TO WORK, IF APPLICABLE: _____
WAS THE IRONWORKER A MEMBER ON THE DATE OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	

SIGN HERE ▶ _____
AUTHORIZED REPRESENTATIVE _____ DATE SIGNED _____

SECTION C TO BE COMPLETED BY ATTENDING PHYSICIAN				
PATIENT'S NAME:	AGE:			
DIAGNOSIS (ICD10):	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/ILLNESS? <input type="checkbox"/> INJURY/ACCIDENT <input type="checkbox"/> SICKNESS/ILLNESS				
DATE SYMPTOMS FIRST APPEARED OR INJURY/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 IRONWORKER 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 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', for each disability
4. Mail completed claim form to:

**IMPACT Off-the-Job Accident 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**