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	☐ MALE ☐ 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_____

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? _____ 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: ☐ APPRENTICE ☐JOURNEYMAN ☐ FOREMAN ☐ GENERAL FOREMAN ☐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? ☐YES ☐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? ☐ YES ☐ NO	PREGNANCY? IF YES, APPROXIMATE DATE OF DELIVERY: ☐ YES ☐ NO
IS CONDITION RESULT OF INJURY/ACCIDENT OR SICKNESS/ILLNESS? ☐ YES ☐ NO	IF YES: ☐ INJURY/ACCIDENT ☐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? ☐ YES ☐ NO IF "YES", WHEN & DESCRIBE:	IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ 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 X	DEGREE TELEPHONE
STREET ADDRESS	CITY – STATE – ZIP CODE

opeiu#8

SEE REVERSE SIDE FOR INSTRUCTIONS

PROCEDURE FOR FILING A CLAIM

- ❑ **Review your claim form carefully**
  - Be sure all information outlined in Section A, B, and C is complete
- ❑ **Sign your claim form**
  - The form must be signed by the ironworker, the Local, and the attending physician
- ❑ **Verify that your claim form was submitted**
  - Be sure the physician or the Local submits the completed claim form if they are sending it on your behalf
- ❑ **Verify your contact information**
  - Ensure your address, email address, and phone number are current and legible
- ❑ **Check your mail**
  - WPAS may send you a form requesting additional information
  - Be sure to promptly complete and return all paperwork WPAS sends to you
- ❑ **If WPAS notifies you that information was requested from the doctor, contact them**
  - Be sure your physician's office promptly completes and returns requested information to WPAS
- ❑ **Apply for Local Union, City, State or Federal government benefits, if applicable**
  - WPAS will need this information in order to calculate benefit offsets
- ❑ **WPAS will ask your health plan to verify eligibility on the date of your injury**
  - Confirm you are eligible under your health plan during the month of your off-the-job injury

- ❑ **Submit completed claim form to:**

Email: claimstatus@wpas-inc.com

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

Fax: (206) 441-9110

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