Alaska Carpenters Health and Welfare Trust Fund FUND 40

WEEKLY ACCIDENT AND SICKNESS CLAIM FORM

This form is for: ☐ 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	☐ MALE ☐ FEMALE	DATE OF BIRTH	SOCIAL SECURITY NO. or ID NUMBER
HOME ADDRESS CITY STATE ZIP			TELEPHONE NO. EMAIL

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: _____

H. Are you entitled to sick leave or disability benefits from any other source including but not limited to Social Security disability benefits, employer provided sick leave or short-term disability, unemployment compensation or workers compensation disability benefits? Yes_____ No_____.

"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."

I certify that my accident injury did not arise as a result of a plan exclusion as listed in the Benefit Description brochure.

SIGN HERE► _____ _____
EMPLOYEE SIGNATURE DATE SIGNED

SECTION B	TO BE COMPLETED BY THE EMPLOYER	
Employer:	Local Union No.	RAB:
Job Classification:		
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 (ICD CODE(S) ONLY):			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? ☐ INJURY ☐ ACCIDENT ☐ SICKNESS				
DATE SYMPTOMS FIRST APPEARED OR 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 EMPLOYEE RETURNED TO WORK:	
DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE X	DEGREE	TELEPHONE
STREET ADDRESS		CITY – STATE – ZIP CODE		

SEE REVERSE SIDE FOR INSTRUCTIONS

PROCEDURE FOR FILING A CLAIM

1. Complete the Employee Section.

2. Have your employer complete the Employer Section.

3. Have your Doctor complete the Attending Physician's Section for each disability.

4. Mail completed claim form to:

Alaska Carpenters Trust Fund
PO Box 34687
Seattle, WA 98124-1687

Or email to claimstatus@wpas-inc.com