## 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: <a href="mailto:claimstatus@wpas-inc.com">claimstatus@wpas-inc.com</a>

## 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 E	BE COMPL	ETED BY T	HE EMPLOYE	E William Street		S 1 1 1 1 1 1 1
EMPLOYEE NAME	Г	MALE FEMALE	DATE OF BIRTH	BOOK NO.	SOCIAL SECURITY N	0.
HOME ADDRESS	CITY	STAT	E ZIP		TELEPHONE NO.	
A. Description of accident or injury		79 30 30				
B. Date of accident or date of injury						
C. Were you at work? ☐ Yes ☐ No	Have you or	will you file for	Workers' Comper	sation Benefits?	☐ Yes	□ No
D. Name of your doctor						
E. Name and address of hospital						
F. Date entered hospital			Date discharge	d		
G. Are you retired?	If yes, when:					
benefits payable in connection with this claim. This data representative will receive a copy of this authorization upon  SIGN HERE  EMPLOYEE SIGNAT  SECTION B  TO 8	request."		HE LOCAL UI	DATI	E SIGNED	my additionized
	ocal Union No		RAB			
Job Classification:				·		
□ Apprentice □ Journeyman □ Foreman □ General Foreman □ Other Basic Weekly Earnings: \$						
Date employee last worked:						
Date employee returned to work, if applicable:						110
SIGN HERE AUTHORIZED REPRESENTATIVE DATE SIGNED						
					E SIGNED	
SECTION C TO BE (	COMPLET	ED BY ATT	ENDING PHY	SICIAN AGE:		
				AGE:		
DIAGNOSIS (ICD9 ONLY):			ITALIZED FOR THIS TE OF ADMIT:	CONDITION		
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATEMPLOYMENT? † YES † NO	IENT'S	PREGNA	ANCY? IF YES, APP	ROXIMATE DATE OF DE	LIVERY:	
IS CONDITION RESULT OF INJURY, ACCIDENT OR SICKNESS?						
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED:		DATE P	ATIENT FIRST CONS	SULTED YOU FOR THIS	CONDITION:	
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? † YES † NO IF "YES", WHEN & DESCRIBE:		IS PATI	ENT STILL UNDER Y	OUR CARE FOR THIS C	ONDITION?	
PATIENT WAS CONTINUOUSLY UNABLE TO WORK FROM: TO:		LAST D	ATE WORKED:			
IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN T	O WORK:	DATE E	MPLOYEE RETURNE	D TO WORK:		
DATE PHYSICIAN'S NAME (PRINT)	510 <b>X</b>	GNATURE		DEGREE	TELEPHONE	
STREET ADDRESS		-	STATE - ZIP CODE			
						12-1106