

COMPLETE AS  
FOLLOWS:

PART 1 EMPLOYEE  
PART 2 & 4 EMPLOYER  
PART 3 PHYSICIAN

# WEEKLY INCOME / DISABILITY WAIVER APPLICATION

RETURN THIS FORM TO:

## WASHINGTON TEAMSTERS WELFARE TRUST

2323 EASTLAKE AVE EAST SEATTLE, WASHINGTON 98102-3393

CLAIMS/BENEFITS ONLY (206) 726-3277 OR 1-800-458-3053

ELIGIBILITY/OTHER (206) 726-3344 FAX (206) 926-2673 OR FAX (206) 926-2672

### PART I – TO BE COMPLETED BY THE EMPLOYEE

EMPLOYEE'S NAME (LAST) (FIRST) (INITIAL)		NAME OF COMPANY YOU WORK FOR		
ADDRESS		DATE EMPLOYED	EMPLOYEE'S DATE OF BIRTH	<input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED
CITY, STATE, ZIP CODE		SOCIAL SECURITY NO.	LOCAL UNION NO.	HOME TELEPHONE NO.
DID YOUR WORK CAUSE THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAS A CLAIM BEEN FILED WITH THE WORKER'S COMPENSATION CARRIER? <input type="checkbox"/> YES <input type="checkbox"/> NO STATE CASE NO.:	FIRST DAY UNABLE TO WORK DATE _____ HOUR _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		IF YOU HAVE RETURNED TO WORK, GIVE DATE OF RETURN
CIRCLE YOUR REGULARLY SCHEDULED DAYS OF WORK SUN MON TUES WED THUR FRI SAT		DID YOUR CONDITION REQUIRE YOU TO UNDERGO OR SCHEDULE SURGERY? IF YES, GIVE SURGERY DATE:		

ARE YOU ENGAGED IN ANY OCCUPATION FOR WAGE OR PROFIT DURING THIS DISABILITY (I.E. SELF-EMPLOYED, OWN YOUR OWN BUSINESS, WORKING PART-TIME AT A DIFFERENT EMPLOYER)?  YES  NO IF YES, PLEASE DESCRIBE NATURE OF THAT WORK:  
HOW MANY HOURS PER WEEK: \_\_\_\_\_ WEEKLY INCOME: \$ \_\_\_\_\_

<b>IF CLAIM IS FOR AN INJURY, YOU MUST COMPLETE THIS SECTION</b>	DATE OF INJURY	TIME	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	WERE YOU AT WORK WHEN INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, FOR WHOM?
	HOW DID INJURY HAPPEN			
	WHERE WERE YOU WHEN INJURED?		NATURE OF INJURY	

I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE ANY PERSON OR INSTITUTION PROVIDING CARE OR SERVICE, OR ANY ORGANIZATION IN POSSESSION OF INSURANCE OR BENEFIT INFORMATION TO RELEASE ANY AND ALL INFORMATION PERTAINING TO THE CARE OR BENEFITS PROVIDED TO ME.

EMPLOYEE'S SIGNATURE	DATE SIGNED
<b>X</b>	<b>← SIGN HERE</b>

### PART 2 – TO BE COMPLETED BY THE EMPLOYER

DATE EMPLOYED	FIRST FULL DAY UNABLE TO WORK	DATE LAST WORKED	DATE RESUMED WORK	DATE EXPECTED TO RESUME WORK
IS THIS DISABILITY THE RESULT OF OCCUPATIONAL DISEASE OR INJURY ARISING IN THE COURSE OF EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE DATE OF ONSET OR INJURY				
HAS EMPLOYEE RETURNED TO WORK ON A PART-TIME OR LIGHT DUTY BASIS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE COMPLETE PART 4 ON THE BACK OF THIS FORM				
EMPLOYER'S SIGNATURE		TELEPHONE NO.	DATE SIGNED	
<b>← SIGN HERE</b>				
PRINT OR TYPE NAME OF PERSON SIGNING		EMPLOYER ADDRESS		

