WESTERN STATES HEALTH & WELFARE
TRUST FUND OF THE OPEIU
1220 SW Morrison, Suite 300
Portland, OR 97205
(800) 547-4457 or (503) 224-0048, Fax (503) 228-0149

THIS SECTION MUST BE COMPLETED BY THE EMPLOYEE FOR BENEFITS TO BE DETERMINED:

NAME______________________________
ADDRESS______________________________
SOCIAL SECURITY#______________________ PHONE____________

Must be completed for Time Loss Benefits and Waiver of Premium:

A. Are you receiving, eligible for, or will you be applying for:

1.	ATO	[ ]	5.	Jones Act	[ ]
2.	Vacation	[ ]	6.	Retirement	[ ]
3.	Sick Pay	[ ]	7.	Unearned Wages	[ ]
4.	Workmen's Compensation	[ ]	8.	Calif. State Disability	[ ]

If receiving any of the above, for what period?____________________

B. Are you receiving any other compensation? [ ] Yes [ ] No

C. Is the condition due to your employment? [ ] Yes [ ] No

D. Is the condition due to an accident of any kind? [ ] Yes [ ] No
If yes, please advise how, when & where the accident occurred:
____

E. Were injuries the result of negligence or the intentional act of a third party? [ ] Yes [ ] No
If yes, please advise how, when & where the accident occurred:
____

F. Are/were you hospitalized? [ ] Yes [ ] No
If yes, what dates? ____________________

G. Are you currently working? [ ] Yes [ ] No

H. Please list your current employer's name, address, & phone number:
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I. Are you still disabled? [ ] Yes [ ] No

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I AM APPLYING FOR: [ ] Time Loss [ ] Disability Waiver Of Premium

____
Signature Date

Continued on back….

THE SECTION MUST BE COMPLETED BY THE ATTENDING PHYSICIAN FOR BENEFITS TO BE DETERMINED:

Please advise of the disabling diagnosis: ____________________________________
____
Date employee first consulted you for this condition?_________________________
Date of last treatment? ____
Frequency of treatment and/or next scheduled treatment?____________________
Dates of total Disability: From:_________________through____________________
(If return to work date is unknown, please estimate. This may be revised later.)
Please cite the clinical evidence which prevents the employee from working:
____
____

Physician's Signature:________________________________Date ________________

Physician'/Clinic Name, address, & phone number:_________________________
____

THIS SECTION MUST BE COMPLETED BY EMPLOYER IF APPLYING FOR TIME LOSS BENEFITS

_______________________________________ has applied for TIME LOSS benefits through the Western States Health Plan. Please answer the following questions and return this form to the above address so we may process the disability claim. If you have any questions please contact the Western States Trust Office, Claims Dept. @ 1-800-547-4457 X 1665.

1. Is the employee receiving:
   ATO [ ] Yes [ ] No for dates:______________________
   Vacation Pay [ ] Yes [ ] No for dates:______________________
   Sick Leave [ ] Yes [ ] No for dates:______________________
   Unearned Wages [ ] Yes [ ] No for dates:______________________
2. Employee's daily shift consists of _______________hours.
3. If this is a work related claim, for which of the following could this employee apply?
   Workmen's Compensation [ ] Yes [ ] No
   Jones Act [ ] Yes [ ] No
4. Is the employee currently working? [ ] Yes [ ] No
   If yes, when did the employee return to work? _______________________
5. What state do you pay state unemployment insurance to? ______________
   Information verified by:____

Title:____________________Phone_____________________Date________________

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