TIME LOSS / DISABILITY WAIVER APPLICATION

RETURN THIS FORM TO:

NORTHWEST ADMINISTRATORS, INC.

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) 726-3229

COMPLETE AS FOLLOWS:

PART I EMPLOYEE
PART II EMPLOYER
PART III PHYSICIAN

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	☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED
CITY, STATE, ZIP CODE	SOCIAL. SECURITY NO.	LOCAL UNION NO.	HOME TELEPHONE NO.

DID YOUR WORK CAUSE THIS CONDITION? ☐ YES ☐ NO	HAS A CLAIM BEEN FILED WITH WORKER'S COMPENSATION? STATE CASE No.: ☐ YES ☐ NO	FIRST DAY UNABLE TO WORK DATE_____ HOUR_____ ☐ A.M. ☐ P.M.	IF YOU HAVE RETURNED TO WORK, GIVE DATE OF RETURN

IF CLAIM IS FOR AN INJURY, YOU MUST COMPLETE THIS SECTION

DATE OF INJURY	TIME ☐ A.M. ☐ P.M.	WERE YOU AT WORK WHEN INJURED? ☐ YES ☐ NO IF YES, FOR WHOM?

HOW DID INJURY HAPPEN

WHERE WERE YOU WHEN INJURED?	NATURE OF INJURY

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: $ _____

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 X ← SIGN HERE	DATE SIGNED

PART II – TO BE COMPLETED BY THE EMPLOYER

DATE EMPLOYED	DATE LAST WORKED	FIRST FULL DAY UNABLE TO WORK	DATE RESUMED WORK	DATE EXPECTED TO RESUME WORK

IS THIS DISABILITY THE RESULT OF OCCUPATIONAL DISEASE OR INJURY ARISING IN THE COURSE OF EMPLOYMENT? ☐ YES ☐ NO

IF YES, GIVE DATE OF ONSET OR INJURY

COMPLETE THIS SHADED SECTION IF DISABILITY IS NOT WORK RELATED AND THE EMPLOYEE HAS RETURNED TO PART-TIME OR LIGHT-DUTY WORK.

IF THE EMPLOYEE IS UNABLE TO RETURN TO HIS OR HER NORMAL DUTIES ON A FULL-TIME BASIS DUE TO WORK RESTRICTIONS BY HIS OR HER PHYSICIAN BUT HAS RETURNED TO PART-TIME OR LIGHT-DUTY WORK, THE EMPLOYEE'S TIME LOSS BENEFITS ARE LIMITED TO THE LESSER OF THE AMOUNT OF BENEFITS NEGOTIATED IN THE COLLECTIVE BARGAINING AGREEMENT OR THE DIFFERENCE BETWEEN THE EMPLOYEE'S BASE WAGE (STRAIGHT-TIME PAY) BEFORE THE DISABILITY AND ANY LIGHT DUTY OR PART-TIME REGULAR-DUTY WAGES. IT IS THE EMPLOYER'S RESPONSIBILITY TO NOTIFY THE TRUST OFFICE IF AN EMPLOYEE HAS RETURNED TO PART-TIME OR LIGHT-DUTY WORK BY SUBMITTING THE INFORMATION BELOW.

HAS EMPLOYEE RETURNED TO WORK ON A PART-TIME OR LIGHT DUTY BASIS? IF YES, PLEASE CHECK ONE.

☐ PART-TIME REGULAR-DUTY ☐ LIGHT DUTY

NUMBER OF STRAIGHT TIME HOURS WORKED WEEKLY PRIOR TO DISABILITY _____ HOURS PER WEEK	STRAIGHT TIME WAGE AT TIME OF DISABILITY (BEFORE WITHHOLDING) $_____ PER HOUR $_____ PER WEEK

HOW MANY HOURS PER WEEK IS EMPLOYEE WORKING PART TIME OR LIGHT DUTY? (COMPLETE DETAILS BELOW)

FROM SUNDAY	THRU SATURDAY	HRS WORKED	HOURLY RATE	FROM SUNDAY	THRU SATURDAY	HRS WORKED	HOURLY RATE
/ /	/ /			/ /	/ /		
/ /	/ /			/ /	/ /		
/ /	/ /			/ /	/ /		

EMPLOYER'S SIGNATURE ← SIGN HERE	TELEPHONE NO.	DATE SIGNED

PRINT OR TYPE NAME OF PERSON SIGNING	EMPLOYER ADDRESS

WEEKLY INCOME / DISABILITY WAIVER APPLICATION

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PART III - TO BE COMPLETED BY ATTENDING PHYSICIAN

PATIENT NAME | AGE

IS CONDITION DUE TO INJURY OR ILLNESS ARISING OUT OF EMPLOYMENT?
☐ YES ☐ NO

IF YES, PLEASE PROVIDE STATE CASE NUMBER AND INDICATE RELATED DIAGNOSES.
STATE CASE No;_____
DIAGNOSES:

DIAGNOSIS AND CONCURRENT CONDITIONS (OR I.C.D.9.)

IS CONDITION DUE TO PREGNANCY? ☐ YES ☐ NO
EXPECTED DATE OF DELIVERY

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

PATIENT WAS CONTINUOUSLY DISABLED (UNABLE TO WORK)
☐ YES ☐ NO
FROM THRU

IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK

DATE(S) PATIENT HAS BEEN SEEN FOR THIS CONDITION

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐YES ☐ NO

WAS PATIENT HOSPITAL CONFINED AS A REGISTERED BED PATIENT? ☐ YES ☐ NO
DATE ADMITTED DATE DISCHARGED

PRINT OR TYPE PHYSICIAN'S NAME AND DEGREE

SOC. SEC. NO. OR TAX ID

STREET ADDRESS | CITY | STATE | ZIP CODE

SIGNATURE (ATTENDING PHYSICIAN) | TELEPHONE NO.

X ← **SIGN HERE** DATE