SOUND HEALTH & WELLNESS TRUST

Formerly known as Retail Clerks Welfare Trust
P.O. Box 21505 • Seattle, WA 98111-3505
(206) 282-4500 • (Toll Free) 1-800-225-7620 (In WA)

TIME LOSS REPORT

(Accident and Sickness Weekly Disability Benefit)

INSTRUCTIONS

1. COMPLETE PART 1 BELOW.
2. HAVE YOUR DOCTOR COMPLETE PART II.
3. HAVE YOUR EMPLOYER COMPLETE REVERSE SIDE.
4. NOTIFY TRUST IMMEDIATELY OF YOUR RETURN TO WORK DATE.
5. HAVE ALL PHYSICIANS TREATING YOU FOR THIS DISABILITY COMPLETE A PHYSICIAN'S STATEMENT.

ANSWER ALL QUESTIONS TO ENSURE PROMPT PAYMENT. MAIL THE COMPLETED SIGNED FORM TO THE ADDRESS SHOWN ABOVE.

PART I — EMPLOYEE'S STATEMENT

1. Name (print) _____ Date of Birth _____ ❑ Male ❑ Female
   (First) (Middle) (Last)
2. Address _____
   (Number) (Street) (City) (State) (Zip)
3. Social Security # _____ Home Phone (_____) _____ Local Union Number _____
4. Employer _____ Employer's Phone (_____) _____
5. Date last worked _____ Date returned to work _____ Date you expect to return to work _____
6. On what date did you first receive medical treatment for this disability? _____ Who were you first treated by? _____
7. Indicate names and addresses of any and all treating physicians during this disability: _____
8. Describe illness or injury _____
9. Is condition due to injury or illness arising out of ANY employment? Yes ❑ No ❑
   If yes, explain _____
10. Are you now receiving Worker's Compensation Time Loss Benefits? Yes ❑ No ❑ If yes, what condition? _____
    Are you receiving wages from another employer? Yes ❑ No ❑

IF DISABILITY WAS DUE TO AN ACCIDENTAL INJURY, ANSWER THE FOLLOWING QUESTIONS:

11. Date accident occurred _____ Where did accident occur _____
    How did accident occur _____
    Was another person or organization responsible for the injury? Yes ❑ No ❑ If yes, who was responsible? _____

I understand that I must be under the continuous care and treatment of a covered provider, disabled such that I am unable to work in the industry, not engaged in other work for wage or profit, and that this is not a result of an accident or injury sustained in employment.

I HEREBY CERTIFY THAT THE FOREGOING STATEMENTS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND HEREBY FURTHER AUTHORIZE MY ATTENDING PHYSICIAN(S), HOSPITAL, OR DEPARTMENT OF LABOR & INDUSTRIES TO FURNISH AND DISCLOSE ALL INFORMATION REQUESTED BY SOUND HEALTH & WELLNESS TRUST. THIS AUTHORIZATION IS VALID FOR 12 MONTHS FROM THE DATE SIGNED.

EMPLOYEE'S SIGNATURE _____ **Date** _____

PART II — PHYSICIAN'S STATEMENT

TO AVOID DELAY, ANSWER ALL QUESTIONS COMPLETELY

Patient's Name _____

1. All diagnoses (ICD codes): _____
2. Estimated date of delivery _____ Type of delivery: Vaginal _____ C-section _____
3. All complicating factors (be specific) _____
4. Treatment plan (be specific) _____
5. Prognosis _____
6. Frequency of visits _____ Date of most recent visit _____ Date of next visit _____
7. Is condition due to injury or sickness arising out of patient's employment? Yes ❑ No ❑
8. Date symptoms first appeared or accident happened _____ Date first consulted for this disability period: _____
   Is patient still under your care for this disability? Yes ❑ No ❑
9. If hospitalized, date of admission _____ Date discharged _____
   Surgical procedure, if any (CPT Code) _____ Date performed/scheduled _____
10. Patient was continuously totally disabled from _____ thru _____ If still disabled, estimated date able to return to work _____
    Is patient able to work part time? _____ If yes, as of what date? _____
11. Name of referring physician (if applicable) _____
    Date first consulted _____ Date of last visit _____
12. Name of physician referred to (if applicable) _____
    Date of first scheduled appointment _____ Phone No. _____

DOCTOR'S SIGNATURE _____ Date _____
Doctor's name **(print or type)** _____ Phone No. _____
Address _____
(Number) (Street) (City) (State) (Zip)

SEE REVERSE SIDE FOR EMPLOYER'S STATEMENT

INSTRUCTIONS FOR THE EMPLOYER

PROVIDE THE LAST DATE THE EMPLOYEE WAS ACTIVELY AT WORK PRIOR TO BECOMING DISABLED.
DO NOT INCLUDE DATES PAID AS VACATION OR SICK LEAVE
PROVIDE THE GROSS MONTHLY WAGE EARNED DURING THE MONTHLY PAYROLL PERIOD USED TO DETERMINE ELIGIBILITY FOR BENEFIT PLAN COVERAGE. THE ELIGIBILITY MONTH IS THE MONTH ENDING TWO MONTHS BEFORE THE MONTH IN WHICH THE EMPLOYEE BECAME DISABLED. FOR EXAMPLE, IF THE EMPLOYEE BECAME DISABLED ON DECEMBER 15, THE GROSS MONTHLY WAGE REQUIRED IS THAT EARNED DURING THE MONTHLY PAYROLL REPORTING PERIOD OF OCTOBER.

PART III — EMPLOYER'S CERTIFICATION

Employee Name _____ Social Security # _____

1. Actual date employee last worked _____ Date returned to work _____
2. Check the month disabled then complete all sections to the right of the month indicated.

Month employee first became disabled: (See No. 10 of Physician statement)	**Report wages worked during:**	**Gross Monthly Wages earned: (includes straight, overtime, premium wages, commissions, vacation, and sick pay)**
❑ January	November	_____
❑ February	December	_____
❑ March	January	_____
❑ April	February	_____
❑ May	March	_____
❑ June	April	_____
❑ July	May	_____
❑ August	June	_____
❑ September	July	_____
❑ October	August	_____
❑ November	September	_____
❑ December	October	_____

3. Payroll reporting period basis for monthly wage reported above:
   ❑ Monthly ❑ 4 weeks ❑ 5 weeks
4. Is part time work (normal job duties) available? Yes ❑ No ❑ Is light duty (full/part time) available? Yes ❑ No ❑
5. Employee's occupation _____
6. Is the disability due to injury or illness arising out of employment? Yes ❑ No ❑
7. Does this disability result in a period of paid or unpaid leave qualified for medical plan coverage under FMLA? Yes ❑ No ❑

Employer's firm name _____ Payroll office phone no. _____

Employer's store address _____ Phone no. _____

Certified by _____ Date _____