# SOUND HEALTH & WELLNESS TRUST
# HOW TO SUBMIT A TIME LOSS CLAIM

1. Part I of Time Loss report must be fully completed (in all fields), signed & dated by the Member, and should include the members MAILING address.

2. A Copy of Part II should be fully completed by each Physician treating you during the disability period. All fields must be completed, and signed and dated by each individual treating Physician, or Specialist, if more than one. The form should include the Physician's professional degree, legibly printed name, complete address, phone & fax number. Members should keep copies of Part I & II Time Loss reports for their records before sending/faxing to your Employer's Corporate Payroll office to Complete Part III.

3. Once Part I and II are fully completed, signed & dated, mail or fax your form to your Employer's Main, Corporate Payroll office for Part III to be completed, signed & dated. Then the Employer forwards the fully completed form(s) to the Trust office. **Please note that the Trust, the Union and the Employer are all three separate entities.**

4. **Please DO NOT complete and submit Time Loss forms in advance.** The Trust requires the ACTUAL Date last worked from the member and Employer. The Trust also requires the ACTUAL certified disability dates from your Physician(s), NOT ESTIMATED DATES FILLED OUT IN ADVANCE. Also, the dates must coincide. In addition, if there is more than a 3-day gap between date last worked and certified disability dates, the Trust will require a detailed reason for the gap.

5. Prior to submission of the completed form, all information should be verified as accurate and complete. Any missing information could lead to the form being sent back for additional information or result in the delay or denial of your Time Loss claim.

6. If a claim is work related, submit to Labor &Industries (L&I)/Workers Comp. If L&I denies the claim, you must follow through with the Appeal Process established through L&I/Workers Comp. If L&I stands on their denial, the Trust requires a copy of the initial denial, and a copy of the appeal denial, to include detailed objective documentation of the work restrictions, treatment plan and a list of all dates treated during the entire disability period, with release to work date from Physician(s).

7. Time loss benefits are made after the member has been disabled long enough to receive a full week's benefit (maximum delay would be 10 days) unless the member returns to work earlier.

8. Please fax or have your Physician(s) fax the date no longer certified disabled, prior to the actual release to work date to avoid overpayments. These notes can be faxed to 206-285-4437, Attn: Time Loss Dept. Overpayments resulting from late notification must be refunded to the Trust.

9. **Be sure to submit a completed Washington State Paid Family & Medical Leave (WSPFML) questionnaire that is included in the Time Loss Claim package. The Sound Health & Wellness Trust is an Employer Sponsored plan. The Trust's Weekly Disability (Time Loss) benefit is not payable during any period of disability a member receives WSPFML benefits. Time Loss claims received without the fully completed WSPML questionnaire will be pended for the receipt of that information. If approved for WSPFML benefits please submit a copy of the Employment Security Department "CLAIM SUMMARY" that shows all dates approved and paid, as well as any dates denied. After receipt of the Claim Summary, the Trust will consider disability benefits for any remaining period of disability not paid by WSPFML. If you apply for WSPFML and benefits are denied, the Trust requires a copy of the denial reason to consider benefits. Any weekly disability benefits issued must be refunded to the Trust for any period of disability that Washington State Paid Family & Medical Leave benefits have been issued.**

11724 NE 195th St. Suite 300
Bothell, WA 98011
(206) 282-4500
(800) 225-7620
www.soundhealthwellness.com

SOUND HEALTH
& WELLNESS TRUST

DATE: _____

Member Name _____

Address _____

City, State, Zip _____

Member ID#: U013 _____

The Trust requires documentation as to if you are applying for or approved for Washington State Paid Family/Medical Leave (PFML) benefits or not during this disability period. Please note that weekly disability benefits are not payable during any period of disability when you are receiving or are eligible to receive benefits under the Washington State Paid Family and Medical Leave. Sound Health & Wellness Trust is not a Private Insurance, it is Employer Sponsored. You cannot receive both WSPFML and Sound Health disability for the same disability benefit period

**Please note:** Federal Family Medical Leave (FMLA) applied for through your Employer protects your job, and the Trust does not require this information. WSPFML benefits applied for through Washington State provide benefits while you are off work for a serious illness or while caring for a family member. (Please note, off work for care of a family member is not covered under Sound Health & Wellness Trust for disability benefits or premium waivers). You can apply for WSPFML benefits at paidleave@esd.wa.gov or call (833)717-2273 with questions about setting up your account through WSPFML. The Trust requires information as to whether you have or have not applied for WSPFML benefits. **Please read letter carefully and check YES or NO below, as part of your Time Loss claim. Response is required.**

1. **APPLYING for WSPFML benefits for this disability period in question. YES___ NO ___**

**Please Note**: If you have applied or are applying for WSPFML benefits, please provide a copy of the Denial or a copy of the all pages of the Approval letter and Claim Summary showing wait period dates, dates paid and any dates denied once you receive them. Any time your Physician extends you off work, submit your extensions through WSPFML first. Then submit copies of Approvals and Claim Summaries to the Trust for further review. If you are disabled beyond the usual 12 to 16 weeks allowed by WSPFML, please also submit a copy of all pages of the continued Approval & Claim Summary in order for the Trust to consider benefits for dates not allowed by WSPFML.

**Please sign & date, and return with any attachments to the Trust at the address shown above or you can fax back to the Time Loss Department at 206-285-4437.**

Please sign & date: _____

Please contact Customer Service at 206-282-4500 or 800-225-7620 with any questions.

Sincerely,

SOUND HEALTH & WELLNESS TRUST

# SOUND HEALTH & WELLNESS TRUST

P.O. Box 21505 • Seattle, WA 98111-3505
(206) 282-4500 • 1-800-225-7620 • Fax (206) 285-4437

# TIME LOSS REPORT

**Employee Weekly Disability Benefit**

## INSTRUCTIONS:

1. COMPLETE PART 1 BELOW, SIGN AND DATE.
2. HAVE YOUR DOCTOR COMPLETE PART II, SIGN AND DATE.
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, SIGN AND DATE.

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

PART I EMPLOYEES STATEMENT

## PART I — EMPLOYEE'S STATEMENT

1. EMPLOYEE NAME (FIRST) (LAST) DATE OF BIRTH ☐ MALE ☐ FEMALE

2. ADDRESS (NUMBER) (STREET) (CITY) (STATE) (ZIP)

| 3. MEMBER ID # U013- _____ | 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 A DIFFERENT EMPLOYER? YES ☐ NO ☐ IF YES, NAME OF EMPLOYER?

***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 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. I ALSO AUTHORIZE THE RELEASE OF THIS INFORMATION TO THE SOUND RETIREMENT TRUST (IF APPLICABLE). THIS AUTHORIZATION IS VALID FOR 12 MONTHS FROM THE DATE SIGNED.

**EMPLOYEE'S SIGNATURE** _____ **DATE** _____

PART II PHYSICUANS STATEMENT

## PART II — PHYSICIAN'S STATEMENT

***The following information is needed to document the patient's inability to work. To avoid delay, answer all questions completely.***

PATIENT'S NAME

1. ALL DIAGNOSES (ICD CODES):

| 2. IF DISABILITY IS FROM PREGNANCY: | ESTIMATED DATE OF DELIVERY | ACTUAL DATE OF DELIVERY | TYPE OF DELIVERY: ☐ VAGINAL ☐ C-SECTION |
|---|---|---|---|

3. ALL COMPLICATING FACTORS DELAYING RECOVERY

4. DESCRIBE PLANNED COURSE AND DURATION OF TREATMENT:

DESCRIBE PATIENT'S PHYSICAL AND/OR MENTAL LIMITATIONS AND RESTRICTIONS (FUNCTIONAL CAPACITY)

5. HOW LONG DO YOU EXPECT THESE LIMITATIONS AND RESTRICTIONS TO IMPAIR YOUR PATIENT?

| 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 ☐
DID YOU COMPLETE A WORKERS" COMPENSATION CLAIM FORM?? 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 ☐

**PHYSICIAN'S STATEMENT CONTINUES ON REVERSE ⇨**
**SEE REVERSE SIDE FOR EMPLOYER'S STATEMENT ⇨**

PART II CONTINUED

## PART II — PHYSICIAN'S STATEMENT, CONTINUED

| 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) | DEGREE | PHONE NO. | FAX NO. |
|---|---|---|---|

| ADDRESS | (NUMBER) | (STREET) | (CITY) | (STATE) | (ZIP) |
|---|---|---|---|---|---|

## 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 EMPLOYERS CERTIFICATION

## PART III — EMPLOYER'S CERTIFICATION

| EMPLOYEE NAME | LAST FOUR OF SOCIAL SECURITY # |
|---|---|
| 1. ACTUAL DATE EMPLOYEE LAST **WORKED** (NOT INCLUDING VACATION, SICK LEAVE OF HOLIDAY) | 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) | 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 | _____ | ☐ July | May | _____ |
| ☐ February | December | _____ | ☐ August | June | _____ |
| ☐ March | January | _____ | ☐ September | July | _____ |
| ☐ April | February | _____ | ☐ October | August | _____ |
| ☐ May | March | _____ | ☐ November | September | _____ |
| ☐ June | April | _____ | ☐ 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 ☐ UNDETERMINED ☐
HAS THE EMPLOYEE FILED FOR WORKER'S COMPENSATION? 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** _____