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 notify the Trust if you are applying for and have been approved or are receiving Washington State Paid Family Medical Leave benefits (WSPFML) when submitting your time Loss claim. If approved, notify the Trust immediately to stop paying disability benefits to avoid overpayments. The Trust requires a copy of the Employment Security Departments Approval letter and the "CLAIM SUMMARY" that shows the Waiting Week, and all dates paid WSPFML benefit with Return of Uncashed checks or Refunds. If you are denied WSPFML benefits, please submit a copy of the Decision of Denial to the Trust.**

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 Washington State Paid Family Medical Leave (WSPFML) or not during this disability period. The Trust only allows disability benefits until WSPFML benefits start being issued. Once WSPFML starts paying benefits, the Trust should be notified immediately to stop paying disability benefits. Please note that weekly disability benefits do not cover any period of disability when you are receiving or are eligible to receive benefits under the Washington State Paid Family and Medical Leave Act.

Please note that Federal Family Medical Leave (FMLA) and WASHINGTON STATE PAID FAMILY MEDICAL LEAVE (WSPFML) are totally different. FMLA applied for through your Employer protects your job. WSPFML benefits applied for through Washington State provides benefits while you are off work for a serious illness or while caring for a family member. 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. If you applied and have been denied, the Trust requires a copy of the denial letter with the explanation for the denial. If applied and approved, the trust requires a copy of the Employment Security Departments Award letter with the Leave approval dates, and the "CLAIM SUMMARY" that shows the wait week dates plus all dates WSPFML benefits were paid. Once this documentation is received, the Trust can review your claim for further benefits. Please check the appropriate box below, then sign/date/return this form with the appropriate WSPFML documentation.

- ❑ NOT applying for PFML during my entire disability period.
- ❑ Applied and Denied. Please submit copy of WSPFML denial letter with this form.
- ❑ Applied and approved/paid. Please submit a copy of the WSPFML Approval letter and Claim Summary with this form.
  If your disability extends beyond the usual 12 weeks allowed by WSPFML, a copy of the Employment Security Department "Claim Summary" showing the last date paid PFML benefits will be required to determine when the Trust can start allowing benefits.

Please sign and date below and return with attachments for further review of your time loss claim.

_____

For any questions, please contact Customer Service at 206-282-4500 or 800-225-7620.

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** _____