SOUND HEALTH & WELLNESS TRUST

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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** _____