ILWU-PMA WELFARE PLAN

Supplemental Weekly Indemnity Benefits Claim Form

Employee to Fill out Part 1; Physician to fill out Part 2

PART 1: EMPLOYEE STATEMENT			
1. Employee Name:	2. Local Number:	3. Registration Number:	4. Social Security Number:
5. Telephone Number:		6. Date Claim Commenced:	

7. Your claim for Weekly Indemnity shows that you will be able to return to work on:

A. If you have already returned to work or if you plan to return to work *before* the date noted above, please indicate your return-to-work date, and return this form to the ILWU-PMA Coastwise Claims Office immediately:
Work Date:

B. If you plan to return to work on the date indicated in #A above, destroy this form.

C. If your doctor feels that you will *not* be able to return to work on the date noted above, have him/her fill out the following portion of this form and return it immediately to the ILWU-PMA Coastwise Claims Office.

Are you a current union official being paid by your local? Yes ☐ No ☐

If so, for how long? Date:

The above answers are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution, druggist, insurance company, employer, labor union or association to release information to ILWU-PMA COASTWISE CLAIMS OFFICE as is required to properly pay all benefits, if any, due me for this claim. Effective August 1, 2024, and upon signing of the attestation, if through error or misrepresentation I receive an overpayment, the Plan will offset any overpayment amount against any future Weekly Indemnity Benefits payable by the Welfare Plan. Weekly Indemnity Claims require recertification from the provider every 90 days.

Employee Signature:	Employee Date:

PART 2: PHYSICIAN'S STATEMENT

(Weekly Indemnity Claims require recertification from the provider every 90-days. Complete and mail to the below address)

1. Patient's Name:

2. If patient will not be able to perform his/her work by the date noted above, please complete the following:

A. Are you still treating this patient: Yes ☐ No ☐

Date of last treatment:

B. What complications, if any or what present condition has prolonged the disability period?

C. Date patient will be able to return to work (if date of return is undetermined, an estimated or approximate date of return will be necessary for continuing claim payment):

Print Physician's Name:	License Number:
Physician's Signature:	Date:

Address (Street, City, State, Zip Code):

Please Return Completed Form to: ILWU-PMA COASTWISE CLAIMS OFFICE, P.O. Box 429101, San Francisco, CA 94142
Tel: 415-919-5828; Fax: 415-801-4092

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