ILWU-PMA WELFARE PLAN

Weekly Indemnity Benefits Claim Form

Employee to fill out Part 1

Physicians to fill out Part 2

PART 1 – EMPLOYEE STATEMENT *(Fill out and take to your doctor)*			
1. Name:	2. Local Number:	3. Registration Number:	4. Social Security Number:
5. Address (Street, City, State & Zip Code):			6. Telephone Number:
7. On what date did you last work before this disability?	8. Has your disability ended? Yes ☐ No ☐	9. If the answer is yes to #8, give date you were available for work:	
10. Is disability due to an accident? Yes ☐ No ☐	11. If the answer is yes to #10, give date:	12. How and where?	
13. Is your disability due to an accident, injury or illness arising out of employment? Yes ☐ No ☐	14. If answer to #13 is yes, have you filed or do you intend to file a claim for benefits under any Federal or State Workers' Compensation Law? Yes ☐ No ☐		
15. Is your disability due to an accident, injury or illness arising or caused by some other party? Yes ☐ No ☐	16. If answer to #15 is yes, have you filed or do you intend to file any legal action or claim against the other party? Yes ☐ No ☐		
17. 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: Employee Signature: _____ Date: _____			

PART 2 – DOCTOR'S CERTIFICATE
(NEXT PAGE)

ILWU-PMA WELFARE PLAN
Weekly Indemnity Benefits Claim Form

PART 2 – CLAIM FOR DISABILITY BENEFITS – DOCTOR'S CERTIFICATE (*Complete and mail to the below address)*			
17. Patient's Name:	18. Doctor's Name as Shown on License:	19. Doctor's Telephone Number:	20. Doctor's State License Number:
21. Doctor's Address (Street, City, State, Country [if not in USA] & Zip Code – *P.O Box is not accepted as the sole address*):			
22. Date patient first treated for present disability?	23. Date of most recent treatment:	24. Frequency of treatment:	
25. Date patient first prevented from working by present disability?	26. Date patient was / will be able to return to work (if return date is undermined, an estimated or approximate date of earliest return will be necessary for claim payment):		
27. Primary ICD10 Diagnosis Code (required unless diagnosis not yet obtained):	28. Secondary ICD10 Diagnosis Code:		
29. Diagnosis (required) – If no diagnosis has been determined, enter objective findings or a detailed statement of symptoms:			
30. Findings – state nature, severity and extent of the incapacitating disease or injury (include any other disabling conditions):			
31. Type of treatment / medication rendered to patient:	32. If patient was hospitalized, provide dates of entry and discharge: From: To:		
33. Date and type of surgery / procedure performed or to be performed?	34. Enter ICD10 Procedure Code:		
35. If patient is now pregnant or has been pregnant, what date did pregnancy terminate or what date do you expect delivery?	36. If pregnancy is / was abnormal, state the abnormal and involuntary complication causing maternal disability:		
37. Based on your examination of patient, is this disability due to an accident, injury or illness arising out of employment? Yes ☐ No ☐	38. Is disability due to an accident, injury or illness caused by some other party? Yes ☐ No ☐		
39. Is disability due to an accident? Yes ☐ No ☐	40. If answer to #39 is yes, how, when (date) and where:		

Doctor's Certification and Signature (REQUIRED): Having considered the patient's regular or customary work, I certify under penalty of perjury that based on my examination, this doctor's Certificate truly describes the patient's disability (if any) and the estimated duration thereof. I further certify that I am a:

_____

(Type of Doctor) *(Specialty if Any)* *(Licensed to Practice in the State of)*

_____

(ORIGINAL SIGNATURE OF ATTENDING DOCTOR – RUBBER STAMP IS NOT ACCEPTABLE) *(DATE)*

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