ILWU-PMA WELFARE PLAN

Weekly Indemnity Benefits Claim Form

Employee to Fill out Part 1; Physician 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, (including PGP and CWOG)?	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: _____

18. Do you want to receive payment by EFT? (If no box is checked, you will continue to receive payment by check until an EFT form is received).

Yes ☐ No ☐

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: _____ Date: _____

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PART 2 – CLAIM FOR DISABILITY BENEFITS – DOCTOR'S CERTIFICATE (Weekly Indemnity Claims require recertification from the provider every 90 days. Complete and mail to the below address)			
1. Patient's Name:	2. Doctor's Name as Shown on License:	3. Doctor's Tel. Number:	4. Doctor's State License No:
5. Doctor's Address (Street, City, State, Country [if not in USA] & Zip Code – *P.O. Box is not accepted as the sole address*):			
6. Date patient first treated for present disability?	7. Date of most recent treatment:	8. Frequency of treatment:	
9. Date patient first prevented from working by present disability?	10. Date patient was/will be able to return to work (if return date is undetermined, an estimated or approximate date of earliest return will be necessary for claim payment):		
11. Primary ICD-10 Diagnosis Code (required unless diagnosis not yet obtained):	12. Secondary ICD-10 Diagnosis Code:		
13. Diagnosis (required) – If no diagnosis has been determined, enter objective findings or a detailed statement of symptoms:			
14. Findings – state nature, severity and extent of the incapacitating disease or injury (include any other disabling conditions):			
15. Type of treatment/medication rendered to patient:	16. If patient was hospitalized, provide dates of entry and discharge: From: To:		
17. Date and type of surgery/procedure performed or to be performed?	18. Enter ICD-10 Procedure Code:		
19. If patient is now pregnant or has been pregnant, what date did pregnancy terminate or what date do you expect delivery?	20. If pregnancy is/was abnormal, state the abnormal and involuntary complication causing maternal disability:		
21. Based on your examination of patient, is this disability due to an accident, injury or illness arising out of employment? Yes ☐ No ☐	22. Is disability due to an accident, injury or illness caused by some other party? Yes ☐ No ☐		
23. Is disability due to an accident? Yes ☐ No ☐	24. If answer to #23 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)

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