Puget Sound Benefits Trust

PLAN 25T

SHORT TERM DISABILITY CLAIM FORM

Administered by
Welfare & Pension Administration Service, Inc. • PO Box 34711 • Seattle, WA 98124-1711 • (800) 331-6158

This form is for: ☐ Initial request for benefits ☐ Supplemental information on active disability claim
☐ Check here if your address is new

TO BE COMPLETED BY THE EMPLOYEE			
EMPLOYEE NAME	☐ MALE ☐ FEMALE	DATE OF BIRTH	SOCIAL SECURITY # or ID #
HOME ADDRESS CITY STATE ZIP			TELEPHONE NO.

I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Insurance Company, Employer or Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable including disability or employment related information concerning this claim to the Plan Administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request.

SIGN HERE► _____ _____
EMPLOYEE SIGNATURE DATE SIGNED

TO BE COMPLETED BY THE EMPLOYER
Employer: Division:
Name of Employee: Sex:
Social Security # or ID #:
Has the employee made claim for, or is he entitled to Workers' compensation Benefits? ☐ Yes ☐ No
Employee's occupation:
Date employee last worked:
Prior to this disability was the employee: ☐ Laid off ☐ On leave ☐ Retired ☐ Discharged
Date returned to work:

SIGN HERE► _____ _____
AUTHORIZED REPRESENTATIVE DATE SIGNED

TO BE COMPLETED BY ATTENDING PHYSICIAN	
PATIENT'S NAME: AGE:	
DIAGNOSIS (ICD10 ONLY):	IF HOSPITALIZED FOR THIS CONDITION GIVE DATE OF ADMIT:
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO	PREGNANCY? IF YES, APPROXIMATE DATE OF DELIVERY: ☐ YES ☐ NO
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED:	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION:
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO IF "YES", WHEN & DESCRIBE:	IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO
PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) FROM: TO:	LAST DATE WORKED:
IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:	DATE EMPLOYEE RETURNED TO WORK:

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE	TELEPHONE
		X		
STREET ADDRESS		CITY	STATE	ZIP CODE

SEE REVERSE SIDE FOR INSTRUCTIONS

PROCEDURE FOR FILING A CLAIM

1. Complete the Employee section.

2. Have your employer complete Employer section.

3. Have your doctor complete the Attending Physician's Section for each disability.

4. Mail completed claim form to:

Puget Sound Benefits Trust
PO Box 34711
Seattle, WA 98124-1711

Phone: (206) 441-7574 or (800) 331-6158