Northwest Carpenters Health and Security Trust
PO Box 1929, Seattle, WA 98111-1929 | (800) 552-0635 | www.CarpentersBenefits.org

Application for Time Loss Benefits

1. You (the carpenter) must complete **Section 1 – Carpenter's Statement of Disability** in its entirety, sign and date it, and then forward it to your attending physician.
2. Your attending physician must complete **Section 2 – Attending Physician's Statement of Disability** in its entirety and then sign and date it. You or your physician must return the completed form to Northwest Carpenters Trusts.

Section 1 – Carpenter's Statement of Disability

1. Name (please print): _____
   (First) (MI) (Last)
2. Address: _____
   (Street) (City) (State) (Zip)
3. Telephone: ( ) _____ Social Security number: _____
4. Date of birth: _____ Employer: _____
5. Occupation (please be specific): _____
6. When did you last work? Month _____ Day _____ 20_____
7. When did you become disabled? Month _____ Day _____ 20_____
8. Describe your disability: _____
9. Is your condition the result of an injury? ☐ Yes ☐ No. If yes, please answer questions (a) - (e):
   (a) Date of injury: Month _____ Day _____ 20_____
   (b) What were you doing when you were injured? _____
   (c) Where were you (please be specific)? _____
   (d) Who is responsible for the accident? Name: _____
   Address: _____ Telephone: ( ) _____
   (e) Does the responsible person (if other than you) have insurance that covers your injury? ☐ Yes ☐ No.
   If yes, what is the name of the insurance company?
10. When did you first seek medical attention? Month _____ Day _____ 20_____
11. Where were you first treated? _____
12. Is your disability the result of a work-incurred injury or illness? ☐ Yes ☐ No
13. Have you returned to work? ☐ Yes ☐ No. If yes, when? _____
14. Are you eligible for a wage continuation program (i.e., sick leave)? ☐ Yes ☐ No
15. Have you applied for or been granted a Social Security Disability award? ☐ Yes ☐ No

Carpenter's Authorization to Release Confidential Information

I hereby certify that the foregoing statements (including any accompanying statements) are true, correct and complete to the best of my knowledge. I further request and authorize my attending physician to release to this plan all facts, records and other information pertaining to my diagnosis, care and treatment. I understand that these records may contain information regarding the diagnosis or treatment of HIV, other sexually transmitted diseases, drug or alcohol abuse, mental illness, or psychiatric treatment. No further disclosure of the requested information will be made in accordance with Federal Law 42 CRF, Part 2. A photostatic copy of this authorization shall be considered as effective and valid as the original.

_____ _____
Carpenter's signature Date signed

See reverse side for Attending Physician's Statement of Disability

Section 2 – Attending Physician's Statement of Disability

Disability History

1. Date symptoms or injury occurred: Month _____ Day _____ 20_____
2. Date of first treatment: Month _____ Day _____ 20_____
3. Date disability commenced: Month _____ Day _____ 20_____
4. Has patient had the same or a similar condition before? ☐ Yes ☐ No. If yes, please state when and describe:

   _____
5. Is this condition a result of an injury or illness arising from patient's employment? ☐ Yes ☐ No
6. Is this condition a result of an auto accident? ☐ Yes ☐ No

Present Condition

1. Subjective symptoms: _____
2. Objective findings: _____
3. Diagnosis: _____
4. Date of first visit: Month _____ Day _____ 20_____
5. Date of last visit: Month _____ Day _____ 20_____
6. Frequency of treatments: ☐ Weekly ☐ Monthly ☐ Other
7. Is this a pregnancy related disability? ☐ Yes ☐ No. If yes, what is the EDC date: _____

Extent of Disability

1. As of this date, is the patient totally disabled (meaning incapable of performing any and every duty pertinent to his or her occupation as a carpenter, and not engaged in any other occupation for wage or profit)? ☐ Yes ☐ No.

   If yes, what *specific* job duties is patient capable or incapable of performing? _____

   _____
2. When did or when should patient be able to return to work? _____

   If unknown, when is patient's next appointment? _____
3. Have you placed any physical restrictions on this patient? ☐ Yes ☐ No. If yes, please explain: _____

   _____

Physician Information

1. Physician's name (please print):_____
2. Address: _____
   (Street) (City) (State) (Zip)
3. Medical degree and specialty: _____ Telephone: (_____) _____

_____ _____

Physician's signature Date signed