

Alaska Electrical Health & Welfare Fund
2600 Denali Street, Suite 200
Anchorage, AK 99503-2782
(907) 276-1246 • (800) 478-1246 • FAX (907) 278-7576

APPLICATION FOR WEEKLY INCOME DISABILITY BENEFITS

INSTRUCTIONS TO PARTICIPANT

1. This form is to be filed as soon as it appears that you will qualify for disability benefits.
To qualify, you must be totally and continuously disabled from performing *the duties of your occupation* because of injury or illness and not engaged in any other occupation for wage or profit.
2. You are to complete front side answering all questions in detail.
3. Your physician must complete the reverse side answering all questions in detail.
4. Return the completed form to the Alaska Electrical Trust Funds.

Part 1-TO BE COMPLETED BY PARTICIPANT:

Name _____ Social Security Number _____

Mailing Address _____ City _____ State _____ Zip Code _____

Home: _____ Telephone Number _____ Work: _____ Date of Birth _____

Current Employer _____ Occupation _____

When did you become totally disabled and unable to work? Date: _____

Has your disability been total and continuous since you became unable to work? Yes No

If yes, approximately when do you feel you will be able to resume work? _____

If no, when did you again become able to work? Date: _____ Hour: _____ A.M. P.M.

Is disability due to: Accident Sickness (If accident, describe, including date and place. If sickness, when did symptoms first appear?) _____

Have you been hospital confined? Yes No If yes, when? From _____ to _____

Name of hospital: _____ Address _____

Did disability result from employment? Yes No

If yes, give amount of weekly benefit you are receiving from Workman's Compensation and forward a copy of the award: \$ _____

Your attending physicians during the past year: _____ Medical Condition: _____ Date consulted: _____

These statements are true and complete to the best of my knowledge.
I hereby authorize any Plan Administrator, insurer, physician, hospital, or Workman's Compensation carrier to disclose and release any information acquired in the course of my examination or treatment.

Participant Signature: _____ **Date:** _____

Part 2-ATTENDING PHYSICIAN'S STATEMENT:

To qualify for disability benefits, a plan participant must be totally and continuously disabled from performing the duties of his/her occupation because of an injury or illness and not engaged in any other occupation for wage or profit.

1. History

- a. When did symptoms first appear or accident happen? Mo. _____ Day _____ Yr. _____
- b. Date patient ceased work because of disability? Mo. _____ Day _____ Yr. _____
- c. Has patient ever had same or similar condition? Yes No If "yes", state when and describe: _____
- d. Did disability result from employment? Yes No Unknown
- e. Names and addresses of other treating physicians: _____

2. Diagnosis

- a. Diagnosis (including any complications): _____
- b. Subjective symptoms: _____

3. Dates of Treatment

- a. Date of first visit: Mo. _____ Day _____ Yr. _____
- b. Date of last visit: Mo. _____ Day _____ Yr. _____
- c. Frequency of current treatment: Weekly Monthly Other (specify) _____

4. Nature of Treatment (Including surgery and medications prescribed, if any) _____

5. Progress

- a. Patient has: Recovered Improved Unchanged Retrogressed
- b. Patient is: Ambulatory House confined Bed confined Hospital confined
- c. Has patient been hospital confined? Yes No If yes, give name and address of hospital: _____
Confined from _____ through _____

6. Prognosis

- | | | |
|---|--|--|
| | <u>PATIENT'S JOB</u> | <u>ANY OTHER WORK</u> |
| a. Is patient currently disabled? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. What duties of patient's job is he/she incapable of performing? | _____ | |
| c. Do you expect a fundamental or marked change in the future? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. If yes, when will/or did patient recover sufficiently to perform duties? | <input type="checkbox"/> 1 mo. <input type="checkbox"/> 3-6 mo | <input type="checkbox"/> 1 mo. <input type="checkbox"/> 3-6 mo |
| | <input type="checkbox"/> 1-3 mo <input type="checkbox"/> Never | <input type="checkbox"/> 1-3 mo <input type="checkbox"/> Never |

Remarks: _____

Physician's name (Print) _____ Degree _____ Specialty _____ Telephone _____

Street Address _____ City _____ State _____ Zip Code _____

Physician's Signature _____ Date _____

TO BE COMPLETED BY OFFICE CERTIFYING COVERAGE:

For administrative office use only:

Certified by: _____ Date: _____