ALASKA ELECTRICAL HEALTH & WELFARE FUND

Application for Weekly Income Disability Benefits

Return form to:
Alaska Electrical H&W Fund
701 E. Tudor, Suite 200
Anchorage, AK 99503
(907) 276-1246 or (800) 478-1246
Fax (907) 278-7576

INSTRUCTIONS TO EMPLOYEE

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. Participant 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

_____ Last 4 Digits of SSN

_____ Mailing Address

_____ City _____ State _____ Zip Code

Home:_____ Work:_____
Telephone Number

_____ 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.

Employee 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 _____ 20 _____
   b. Date patient ceased work because of disability? Mo. _____ Day _____ 20 _____
   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 _____ 20 _____
   b. Date of last visit: Mo. _____ Day _____ 20 _____
   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**

	PATIENT'S JOB	ANY OTHER WORK
a. Is patient currently disabled?	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No
d. If yes, when will/or did patient recover sufficiently to perform duties?	☐ _____ ☐1 mo. ☐3-6 mo. ☐1-3 mo. ☐ never	☐ _____ ☐1 mo. ☐3-6 mo. ☐1-3 mo. ☐ 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: _____