ALASKA ELECTRICAL
HEALTH & WELFARE PLAN
701 E. Tudor, Suite 200
Anchorage, AK 99503
(907) 276-1246
Toll Free: (800) 478-1246

Application for Weekly Income Disability Benefits

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

Full Name ______________________________ Last 4 digits of SSN ____________

Mailing Address ______________________ City ____________ State ______ Zip Code ______

Home/Cell Phone ____________ Work Phone ____________ Date of Birth ______ / ______ / ______

Current Employer ______________________ Occupation ______________________

When did you become totally disabled and unable to work? ______ / ______ / ______

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? ______ / ______ / ______ Hour: ____________ ☐ AM ☐ PM

Is disability due to: ☐ Disability ☐ Sickness

____

If **accident**, describe how it occurred, including date and place. If **sickness**, when did symptoms first appear?

Have you been hospital confined? ☐ Yes ☐ No If **yes**, when? ______ / ______ / ______ TO ______ / ______ / ______

____

Name of Hospital and 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? _______ / _______ / _______
b. Date patient ceased work because of disability? _______ / _______ / _______
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: _______ / _______ / _______
b. Date of last visit: _______ / _______ / _______
c. Frequency of current treatment? ☐ Weekly ☐ Monthly ☐ Other: ______________________

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. If patient has been hospital confined, give name and address of hospital: ______________________
____
Confined from: _______ / _______ / _______ to _______ / _______ / _______

6. Prognosis

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

Physician's Name	Degree	Specialty	Telephone

Mailing Address	City	State	Zip Code

Physician's Signature	Date

TO BE COMPLETED BY OFFICE CERTIFYING COVERAGE
For administrative office use only:

Certified By	Date