ILWU-PMA WELFARE PLAN
Supplemental Weekly Indemnity Benefit Claim Form

PART 1 – EMPLOYEE STATEMENT			
1. Employee Name:	2. Local Number:	3. Registration Number:	4. Social Security Number:
5. Telephone Number:		6. Date Claim Commenced:	

7. Your claim for Weekly Indemnity shows that you will be able to return to work on:

_____

A. If you have already returned to work or if you plan to return to work ***before*** the date noted above, please indicate your return to work date, and return this form to the ILWU-PMA Coastwise Claims Office immediately:

Work Date: _____

B. If you plan to return to work on the date indicated in #A above, destroy this form.

C. If your doctor feels that you will ***not*** be able to return to work on the date noted above, have him/her fill out the following portion of this form and return it immediately to the ILWU-PMA Coastwise Claims Office.

8. Are you a current union official being paid by your local? Yes ☐ No ☐

If so, for how long? Date: _____

By signing below, I attest that I am not and will not collect state benefits while collecting Weekly Indemnity benefits for the same time period. Employee Signature:	Employee Date:

PART 2 – PHYSICIAN'S STATEMENT	

1. Patient's Name:

2. If patient will not be able to perform his / her work by the date noted above, please complete the following:

A. Are you still treating this patient: Yes ☐ No ☐

Date of last treatment: _____

B. What complications, if any or what present condition has prolonged the disability period?

_____

C. Date patient will be able to return to work (if date of return is undetermined, an estimated or approximate date of return will be necessary for continuing claim payment):

_____

Print Physician's Name:	License Number:
Physician's Signature:	Date:
Address (Street, City, State, Zip Code):	

Please Return Completed Form to: **ILWU-PMA COASTWISE CLAIMS OFFICE**
P.O. Box 429101, San Francisco, CA 94142
Tel: 415-919-5828; Fax: 415-801-4092