ILWU-PMA WELFARE PLAN
Weekly Indemnity Benefits Claim Form

Employee to fill out Part 1

Physicians to fill out Part 2

PART 1 – EMPLOYEE STATEMENT
(Fill out and take to your doctor)

1. Name:	2. Local Number:	3. Registration Number:	4. Social Security Number:
5. Address (Street, City, State & Zip Code):			6. Telephone Number:

7. On what date did you last work before this disability?	8. Has your disability ended? Yes ☐ No ☐	9. If the answer is yes to #8, give date you were available for work:
10. Is disability due to an accident? Yes ☐ No ☐	11. If the answer is yes to #10, give date:	12. How and where?

13. Is your disability due to an accident, injury or illness arising out of employment? Yes ☐ No ☐	14. If answer to #13 is yes, have you filed or do you intend to file a claim for benefits under any Federal or State Workers' Compensation Law? Yes ☐ No ☐
15. Is your disability due to an accident, injury or illness arising or caused by some other party? Yes ☐ No ☐	16. If answer to #15 is yes, have you filed or do you intend to file any legal action or claim against the other party? Yes ☐ No ☐

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

If so, for how long? Date: _____

18. Do you want to receive payment by EFT? (If no box checked it will default to check payment until EFT form received)

Yes ☐ No ☐

The above answers are true and complete to the best of my knowledge and belief. I authorize any physician, medical institution, druggist, insurance company, employer, labor union or association to release information to ILWU-PMA COASTWISE CLAIMS OFFICE as is required to properly pay all benefits, if any, due me for this claim. By signing below, I also attest that I am not and will not collect state benefits while collecting Weekly Indemnity benefits during the same time period.

Employee Signature: _____ Date: _____

PART 2 – DOCTOR'S CERTIFICATE
(NEXT PAGE)

ILWU-PMA WELFARE PLAN
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PART 2 – CLAIM FOR DISABILITY BENEFITS – DOCTOR'S CERTIFICATE
(*Complete and mail to the below address)*

1. Patient's Name:	2. Doctor's Name as Shown on License:	3. Doctor's Telephone Number:	4. Doctor's State License Number:
5. Doctor's Address (Street, City, State, Country [if not in USA] & Zip Code – *P.O Box is not accepted as the sole address*):			
6. Date patient first treated for present disability?	7. Date of most recent treatment:	8. Frequency of treatment:	
9. Date patient first prevented from working by present disability?	10. Date patient was / will be able to return to work (if return date is undermined, an estimated or approximate date of earliest return will be necessary for claim payment):		
11. Primary ICD10 Diagnosis Code (required unless diagnosis not yet obtained):	12. Secondary ICD10 Diagnosis Code:		
13. Diagnosis (required) – If no diagnosis has been determined, enter objective findings or a detailed statement of symptoms:			
14. Findings – state nature, severity and extent of the incapacitating disease or injury (include any other disabling conditions):			
15. Type of treatment / medication rendered to patient:	16. If patient was hospitalized, provide dates of entry and discharge: From: To:		
17. Date and type of surgery / procedure performed or to be performed?	18. Enter ICD10 Procedure Code:		
19. If patient is now pregnant or has been pregnant, what date did pregnancy terminate or what date do you expect delivery?	20. If pregnancy is / was abnormal, state the abnormal and involuntary complication causing maternal disability:		
21. Based on your examination of patient, is this disability due to an accident, injury or illness arising out of employment? Yes ☐ No ☐	22. Is disability due to an accident, injury or illness caused by some other party? Yes ☐ No ☐		
23. Is disability due to an accident? Yes ☐ No ☐	24. If answer to #23 is yes, how, when (date) and where:		

Doctor's Certification and Signature (REQUIRED): Having considered the patient's regular or customary work, I certify under penalty of perjury that based on my examination, this doctor's Certificate truly describes the patient's disability (if any) and the estimated duration thereof. I further certify that I am a:

_____

(Type of Doctor) *(Specialty if Any)* *(Licensed to Practice in the State of)*

_____

(ORIGINAL SIGNATURE OF ATTENDING DOCTOR – RUBBER STAMP IS NOT ACCEPTABLE) *(DATE)*

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