

# Heating, Piping & Refrigeration Medical Fund Non-Occupational Time Loss Form

Administered by

Welfare & Pension Administration Service, Inc. • PO Box 34567 • Seattle, WA 98124-1567 • (800) 618-2879

hprclaims@wpas-inc.com

This form is for:  Initial request for benefits  Supplemental information on active disability claim  
 Check here if your address is new

TO BE COMPLETED BY THE EMPLOYEE			
EMPLOYEE NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	SOCIAL SECURITY # or ID #
HOME ADDRESS	CITY	STATE	ZIP
			TELEPHONE NO.
EMPLOYER:	AREA:		
JOB CLASSIFICATION:			
<input type="checkbox"/> APPRENTICE	<input type="checkbox"/> JOURNEYMAN	<input type="checkbox"/> FOREMAN	<input type="checkbox"/> GENERAL FOREMAN <input type="checkbox"/> HELPER
DATE LAST WORKED:			
DATE RETURNED TO WORK, IF APPLICABLE:			

- A. DESCRIPTION OF ACCIDENT OR SICKNESS \_\_\_\_\_
- B. DATE OF ACCIDENT OR BEGINNING OF SICKNESS \_\_\_\_\_
- C. WERE YOU AT WORK?  YES  NO
- IF YES, PLEASE FILE A CLAIM WITH YOUR EMPLOYER'S WORKER'S COMPENSATION INSURANCE COMPANY. ONCE YOUR CLAIM IS ACCEPTED BY THE WORKER'S COMPENSATION INSURANCE AND YOU ARE RECEIVING BENEFITS, YOU MAY BE ELIGIBLE TO APPLY FOR SUPPLEMENTAL OCCUPATIONAL TIME LOSS.
- D. NAME OF DOCTOR \_\_\_\_\_
- E. NAME AND ADDRESS OF HOSPITAL \_\_\_\_\_
- F. DATE ENTERED HOSPITAL \_\_\_\_\_ DATE DISCHARGED \_\_\_\_\_
- G. ARE YOU RETIRED?  YES  NO  
 IF NO, ANTICIPATED DATE OF RETIREMENT: \_\_\_\_\_ IF YES, WHEN: \_\_\_\_\_

"I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Insurance Company, Employer or Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable including disability or employment related information concerning this claim to the Plan Administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request."

**SIGN HERE ►** \_\_\_\_\_

TO BE COMPLETED BY ATTENDING PHYSICIAN	
PATIENT'S NAME:	AGE:
DIAGNOSIS (ICD10 ONLY):	IF HOSPITALIZED FOR THIS CONDITION GIVE DATE OF ADMIT:
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	PREGNANCY? IF YES, APPROXIMATE DATE OF DELIVERY: <input type="checkbox"/> YES <input type="checkbox"/> NO
IS CONDITION RESULT OF INJURY, ACCIDENT OR SICKNESS? <input type="checkbox"/> SICKNESS <input type="checkbox"/> INJURY <input type="checkbox"/> ACCIDENT	
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED:	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION:
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES", WHEN & DESCRIBE:	IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO
PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) FROM: TO:	LAST DATE WORKED:
IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:	DATE EMPLOYEE RETURNED TO WORK:
DATE	PHYSICIAN'S NAME (PRINT)
SIGNATURE	DEGREE
TELEPHONE	
STREET ADDRESS	CITY - STATE - ZIP CODE

SEE REVERSE SIDE FOR INSTRUCTIONS

## **PROCEDURE FOR FILING A CLAIM**

1. Complete the Employee section.
2. Have your doctor complete the Attending Physician's Section.
3. Mail completed claim form to:

**Heating, Piping and Refrigeration Medical Fund  
PO Box 34567  
Seattle, WA 98124-1567  
Phone (410) 444-3756 or (800) 618-2879 \* Fax (206) 441-9110**