IDAHO PIPE TRADES TRUST

Administrative Office

Idaho Pipe Trades
Health & Welfare Trust
LU 296 & LU 648

Plumbers & Pipefitters
Pension Trust
LU 296 LU 648 LU 41

Return completed form to:
Idaho Pipe Trades Trust
Claims Department
PMB#116
5331 S Macadam Ave. Suite 258
Portland, OR 97239

Trust Fund Phone #: **(208) 288-1610**
Toll Free #: **(800) 808-1687**
Fax #: **(503) 208-9223**
Email: **pdxflexclaims@benesys.com**

Part 1 – To be completed by PARTICIPANT (**Each question must be fully answered**)

Active Member _____ Working Retiree _____ (please select one) Must notify the Trust Fund Office if/when you return to work

Name _____ Birth date: _____ SSN: _____

Street _____ Last date of work before disability _____

City and State _____ Zip code _____ Member's Phone# _____

My disability is _____ Injury? _____ Illness? _____

Sickness/injury happened: Date _____ Time _____ At Work? _____ At Home? _____

How did it happen? _____

Job Description/title? _____

To Physicians, Hospitals and Other Institutions: I hereby authorize you by this form (or by photographic copy hereof) to give Idaho Pipe Trades Health and Welfare Trust Fund any information you have regarding my medical history and physical condition.

I certify the above answers are true and complete to the best of my knowledge and belief.

_____ _____
SIGNATURE – Please Do Not Print DATE

Part II – ATTENDING PHYSICIAN'S STATEMENT

1. Nature of sickness or injury/ICD9 (Describe complications if any) _____

2. Was this sickness or injury caused by patient's employment? Yes_____ No_____
   Illness? _____ Injury? _____
   Was it aggravated by Patient's employment? If "Yes" explain _____

3. Nature of surgical procedure, if any/CPT (Describe fully) _____

4. Date performed: _____

5. Give dates of treatments:

	FIRST CONSULATION	OTHER CONSULTATIONS DURING THIS PERIOD OF DISABILITY
Office	_____	_____
Hospital	_____	_____

6. The patient has been continuously disabled (unable to work):From _____ Through (if unsure give tentative date) _____

If still disabled, when should patient be able to return to work? _____

7. Remarks _____

Date _____ Physician's Name (Print) _____ Degree _____

Physician's Signature _____

Address _____

Physician's Phone Number _____

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Part III - To be completed by BY EMPLOYER (if currently employed) Or UNION (If not dispatched)

Employee Name: _____ Date Employee Stopped Work: _____

Has employee returned to work? Yes ☐ : Date returned_____ No ☐: Date expected to return_____

Employer or Union Name/Local number: _____

Mailing Address:_____ City/State_____ Zip_____

Name (please print):_____

Signature_____ Title_____

PMB #116 · 5331 S Macadam Avenue Suite 258, · Portland, OR 97239
Telephone (800) 808-1687 or (208) 288-1610 FAX (208)288-1670
www.iptt.org