THE EMPLOYEE PAINTERS' TRUST HEALTH & WELFARE FUND

Updated: 10/01/2024

WEEKLY SHORT-TERM DISABILITY/TIME LOSS

Please Note:
IT IS YOUR RESPONSIBILITY TO PROVIDE ALL INFORMATION NECESSARY TO PROCESS AND/OR EXTEND YOUR CLAIM.
ALL applications are sent to Innovative Care Management for Independent Medical Necessity Review.
To avoid any delays in processing your benefits, your application must **be completed in its entirety** attaching **all related Medical Records** (examples below) and copies of **2 recent paystubs**.
We do not contact physicians or employers.
You will be notified via note on your weekly check stub if an extension is required to continue payment.
Incomplete applications will be returned for completion.

Weekly Disability Payments:

- The Plan pays benefits while you remain totally disabled, are under a physician's care, and you are not receiving compensation from any other sources.
- Weekly benefit: 80% of your gross weekly wage (based on a 40-hour work week), up to $350.00 or $750.00 (determined by your Collective Bargaining Agreement)
- Waiting period: Disability pay will begin after the application review and approval, from the 1st day of injury; or the 8th day of illness.
- Filing Deadline: Within 90 days, but no later than 12 months after first date of disability.
- Maximum Payments: 26 weeks, or until released to return to work per disability.

Medical Records Required:

Please Submit: Office Visit Chart Notes, History & Physical Chart Notes/Test Results, Imaging/X-Ray Reports, Lab Test Results, Pre-operative Visit Notes/Test Results, Operative Reports, Post-Operative Visit Notes/Test Results. Physical Therapy Visit Notes
Please Do NOT Submit: After Visit Summaries, Discharge Instructions, or Admitting Paperwork.
We require the actual medical records and test results for review.

Health and Welfare Premium Waivers for Eligibility

**NOTE: Non-Bargaining Flat-Rate members are *not* eligible for the Premium Waiver portion of the disability benefit.

- If you are an Active Hourly member disabled due to a non-occupational injury, your health and welfare hour bank is frozen, but you will remain eligible without drawing from your hour bank for a **lifetime maximum of 3 months**.
- Once the maximum is met, if you still have not returned to work, your hour bank will be used to maintain coverage.
- If a member uses all three months of the benefit with one disability, they will **not** qualify for any extension with future disability claims.
- If you are still disabled after the free coverage, and your active hour bank has been depleted, your coverage may be continued by making a self-payment through COBRA for up to 18 months.

~OVER~

5200 Southcenter Blvd., Suite 205, Tukwila, WA 98188 • P O Box 58830 • Tukwila, WA 98138
Phone (206) 518-9730 • Toll Free (844) 344-2721 • Fax (425) 251-1976
www.IUPATWesternBenefits.org

Extensions:

- If there is any change in your return to work date, an update from your physician is required giving us the next expected or approximate Return to Work Date (actual date or timeframe required).
- The Claims Department may also request an update if it has been more than 6 weeks without one, *regardless of the return to work date listed on your initial claim form.*

You will l be liable to repay the Fund in full any disability payments received after your return to work date. The Fund will continue to pursue collection of payments in court, if necessary, until payment in full is received.

Payment Schedule:

Disability checks are mailed weekly, excluding holidays, every Friday once your application has been completed and the Independent Medical Review has been approved. This usually takes 7-10 business days if all required records are sent. To avoid a delay in payment, the Trust allows payment of up to 3 weeks of benefits while the Independent Review is pending for any reason.

Paperwork can be mailed to: The Employee Painters Trust, Attn: Disability, PO Box 58830, Tukwila, WA 98188 or faxed to (425) 251-1976 Attn: Disability, or emailed to staff@iupatwesternbenefits.org Attention Disability.

Please contact the Eligibility Department at Trust Office at (844) 344-2721 with any questions.

Sincerely,

The Eligibility Department
Employee Painters Trust Health & Welfare Trust

THE EMPLOYEE PAINTERS' TRUST HEALTH & WELFARE FUND
Application - Temporary Total Disability

Return completed form to:
The Employee Painters' Trust
PO Box 58830
Tukwila, WA 98138

Trust Fund Phone #: (206) 518-9730
Toll Free #: (844) 344-2721
Fax #: (425) 251-1976

PART I – EMPLOYEE TO COMPLETE IN FULL
(Please attach copies of 2 recent paystubs and all related medical records.)

Name: _____ **Birth date:** _____ **SSN:** _____

Street: _____ **E-mail Address:** _____

City and State: _____ **Zip:** _____ **Member's Phone:** _____

Description of Disability: _____ **Injury?** _____ **Illness?** _____

Are you receiving any other compensation (FMLA/Vacation/Sick/PTO) during any portion of your disability? (circle) YES / NO

If YES, what dates have/will you receive compensation for: _____

Date of Injury/Illness: _____ **Time:** _____ **At Work?** _____ **At Home?** _____

How did it happen? _____

Job Description: _____

Last full day of work prior to disability: _____

I hereby Authorize my Providers by this form (or by photocopy) to RELEASE ANY RECORDS you have regarding my disability to Employee Painters' Trust Fund and/or Innovative Care Management. I certify the above answers are true and complete to the best of my knowledge and belief.

Date: _____ **PATIENT SIGNATURE:** _____
Signature Only - Do Not Print

PART II – EMPLOYER STATEMENT

1. Was this illness or injury caused by the employee's employment? YES / NO
2. Is the employee currently receiving compensation while unable to work? YES / NO

If "Yes" explain the following:

Compensation effective date: _____ **Frequency of the compensation:** _____

Amount of compensation: _____ **Who the compensation is paid by:** _____

Date: _____ **Employer Signature:** _____

Employer Phone Number: _____ **Employer Name:** _____

PART III – PHYSICIAN'S STATEMENT

Per the release signed above, PLEASE ATTACH ALL CLINICAL RECORDS applicable to substantiate disability. Including but not limited to: Office Visit Chart Notes, History & Physical Chart Notes, Imaging/X-Ray Reports, Lab Test Results, Pre-operative Visit Notes/Test Results, Operative Reports, Post-Operative Visit Notes/Test Results, etc.

1. **Nature of illness or injury/ICD9 (Describe complications if any):** _____
_____ **Illness?** _____ **Injury?** _____

2. Was this illness or injury caused by patient's employment: YES / NO Was it aggravated by Patient's employment? YES / NO

If "Yes" please explain: _____

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

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4. Date Surgery Performed: _____ **Was Patient Hospitalized: Admission Date**: _____

Discharge Date: _____

5. Give Dates of Treatments:

FIRST CONSULATION	OTHER OFFICE VISITS DURING THIS PERIOD OF DISABILITY
Office _____	_____
Hospital _____	_____

6. The patient has been continuously disabled (unable to work): From: _____

Through (approximate date is ok): _____

Additional Comments: _____

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

Physician's Signature _____

Address _____

Physician's Phone Number: _____ **Physician's Fax Number:** _____

Revised 9/23/2024