THE NELSON TRUST
PMB #116, 5331 S Macadam Ave, Ste 258
Portland, OR 97239
Phone: (800) 811-8853

STATEMENT OF SHORT TERM DISABILITY CLAIM

EMPLOYEE'S STATEMENT

Employee Name (Last) (First) (Initial)	Employer Name		Hourly Wage $
Employee Address	Date Employed	Employee Birthdate	Sex ❑ Male ❑ Female
City, State, Zip Code	Social Security Number		Home Telephone No.
Did Your Work Cause This Condition? If Yes, Date of Injury? ❑ Yes ❑ No	Have you or will you file a claim with Worker's Compensation? ❑ Yes ❑ No		
Name and address of Worker's Compensation carrier providing benefits for this claim:	Has your Worker's Comp claim been accepted? ❑ Yes ❑ No If your claim has been denied, please attach a copy of the Worker's Compensation Denial.		
First Full Day Unable to Work	Time ❑ a.m. ❑ p.m	If partially disabled, first day unable to work full-time	Date you expect to return to work / If you have returned to work, please give date: Full-time: Part-time: # of hours per day:

IF CLAIM IS FOR AN INJURY COMPLETE THIS SECTION	Date of injury	Time ❑ a.m. ❑ p.m.	Were you at work when injured? ❑ Yes ❑ No	If yes, for whom?
	How did injury happen?			
	Where were you when you were injured?			

I **certify that the above statements are true and complete to the best of my knowledge and belief.**

Employee Signature ▶ | Date

EMPLOYER or LOCAL MUST PROVIDE INFORMATION BELOW

Date Employed	❑ Hourly ❑ Salary	Current Salary Per Hour/WK $	Regularly Scheduled Hours Per Week	Title: Attach Job Description / Is this employee SSI exempt: ❑ Yes ❑ No
Is this disability the result of occupational disease or injury arising in the course of employment? ❑ Yes ❑ No			If related to employment, has a claim been filed with Worker's Compensation? ❑ Yes ❑ No / Has the claim been accepted: ❑ Yes ❑ No Denied: ❑ Yes ❑ No	
First Day Unable to Work	Date Resumed Work		Date Employee is Expected to Resume Work ❑ Full-time ❑ Part-time	If employee is released to light or modified duty, can you accommodate?
If disability began on last day worked, show hours worked that day:			If regular work week other than Monday thru Friday, describe:	

If disability began after last day worked, show reason for leaving work:
Disability ❑ Quit ❑ Vacation ❑ Leave of Absence ❑ Temporary Layoff ❑ Dismissed ❑ Other ❑ - Explain :

List Primary Job Duties	How physically challenging are the job duties? ❑ Light ❑ Moderate ❑ Heavy

We hereby warrant that this employee was on payroll and insured on the date this claim was incurred.

Name of Employer: Location or Branch: Local Union#:

AUTHORIZED EMPLOYER or LOCAL REPRESENTATIVE Signature	Title	Date	Phone #

SEE REVERSE SIDE OF FORM

NT-138 (71(13)

Page 2 must be also be completed by employee and physician.

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Employee Name (Last) (First) (Initial)	Social Security Number	Employer Name	Group Number

The following authorization will be used to obtain additional information (if necessary) concerning this claim.

Authorization for Release of Information

Persons or Institutions: This authorizes you to give The Nelson Health and Welfare Trust ("Trust"), any and all PHI requested by the Trust including without limitation, my medical history, diagnosis and treatment. Moreover, please furnish any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, state disability, earnings and employment history needed to evaluate my claim for disability benefits.

I understand that any information obtained pursuant to this authorization will be used only to evaluate my claim and may be given to any business associate employed by, or representing the Trust to assist with this claim. This authorization will expire one (1)year after I recover from my disability. I understand that the Trust has the right to deny disability benefits if I do not sign this authorization. A photocopy of this authorization is as valid as the original.

Employee Signature ▶ Date

PHYSICIAN'S STATEMENT OF DISABILITY

To Be Furnished Without Expense

Patient Name	Age	Address	

Diagnosis and Concurrent Conditions (ICD-9)	Nature of Surgical Procedure, if any	Date:

Is condition due to injury or illness arising out of employment? ❑ Yes ❑ No	Has a claim been filed with a Worker's Comp carrier? ❑ Yes ❑ No	If yes, please identify	If condition is due to pregnancy, what is the expected date of delivery?	Expected type of delivery?

Date symptoms first appeared or accident happened	Date patient first consulted you for this condition	Is patient still under your care for this condition? ❑ Yes ❑ No

Give Treatment Dates – Office	ER	Outpatient Facility	Hospital – Admission	Discharge

Was patient treated by another provider for this disability? ❑ Yes ❑ No If Yes, show dates, name and address of Provider

Was patient continuously disabled (unable to work) in their own occupation? Full-time: ❑ Yes ❑ No Part-time: ❑ Yes ❑ No	From	Thru

If still disabled, date patient should be able to return to work: _____ _____	Own Occupation? ❑ Full-Time ❑ Part-Time Any Occupation? ❑ Full-Time ❑ Part-Time	If Part-Time. # of hours

Describe impairments, if any, precluding patient from performing the essential duties of the patient's regular occupation OR engaging in any substantial gainful employment. If patient's current job duties could be modified to facilitate early return to work, please describe such modifications:
To Full-time work:

To Part-time or light-duty work:

(City, State, Zip Code)	Telephone Number

Print or Type Physician's name and degree(s)	Attending Physician's Signature ▶

Physician's Address (Street)	Date