UNITE HERE
NORTHWEST TRUST FUNDS

2323 EASTLAKE AVE E. • SEATTLE, WA • 98102
LOCAL (206) 753-1097 OR TOLL FREE (844) 411-0786

COMPLETE AS FOLLOWS:

PART I **EMPLOYEE**
PART 2 **EMPLOYER**
PART 3 **PHYSICIAN**
PART 4 **EMPLOYEE**

WEEKLY INCOME / DISABILITY EXTENSION APPLICATION

RETURN THIS FORM TO:

NORTHWEST ADMINISTRATORS, INC.
Attn: UNITE HERE Northwest Trust Funds
PO Box 20231 Seattle, WA 98102

CLAIMS/BENEFITS/ELIGIBILITY: (206) 753-1097 OR 1-844-411- 0786 FAX (206) 926-2773

PART I – TO BE COMPLETED BY THE EMPLOYEE

EMPLOYEE'S NAME (LAST) (FIRST) (INITIAL)		NAME OF COMPANY YOU WORK FOR	
ADDRESS	DATE EMPLOYED	EMPLOYEE'S DATE OF BIRTH	☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED
CITY, STATE, ZIP CODE	SOCIAL. SECURITY NO.	LOCAL UNION NO.	HOME TELEPHONE NO.

DID YOUR WORK CAUSE THIS CONDITION? ☐ YES ☐ NO	HAS A CLAIM BEEN FILED WITH THE WORKER'S COMPENSATION CARRIER? ☐ YES ☐ NO STATE CASE NO.:	FIRST DAY UNABLE TO WORK DATE_____ HOUR_____ ☐ A.M. ☐ P.M.	IF YOU HAVE RETURNED TO WORK, GIVE DATE OF RETURN:

CIRCLE YOUR REGULARLY SCHEDULED DAYS OF WORK
SUN MON TUES WED THUR FRI SAT

DID YOUR CONDITION REQUIRE YOU TO UNDERGO OR SCHEDULE SURGERY? ☐ YES ☐ NO SURGERY DATE:

OTHER INCOME YOU ARE RECEIVING, HAVE FILED FOR, OR ARE ELIGIBLE FOR:

	DATE CLAIM FILED	INCOME EFFECTIVE DATE	WEEKLY BENEFIT AMOUNT
1. WORKERS' COMPENSATION:			
2. WA STATE PAID FAMILY & MEDICAL LEAVE:			

IF HOSPITALIZED, NAME OF HOSPITAL:
_____
DATE ADMITTED: _____
DATE RELEASED: _____

IMPORTANT: IF YOU ARE OFF WORK DUE TO QUARANTINE FOR COVID-19, YOU MUST COMPLETE PART 4.*

IF CLAIM IS FOR AN INJURY, YOU MUST 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 INJURED?		NATURE OF INJURY:

I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE ANY PERSON OR INSTITUTION PROVIDING CARE OR SERVICE, OR ANY ORGANIZATION IN POSSESSION OF INSURANCE OR BENEFIT INFORMATION TO RELEASE ANY AND ALL INFORMATION PERTAINING TO THE CARE OR BENEFITS PROVIDED TO ME.

EMPLOYEE'S SIGNATURE X ← SIGN HERE	DATE SIGNED

PART 2 – TO BE COMPLETED BY THE EMPLOYER

DATE EMPLOYED	FIRST FULL DAY UNABLE TO WORK	DATE LAST WORKED	DATE RESUMED WORK	DATE EXPECTED TO RESUME WORK

IS THIS DISABILITY THE RESULT OF OCCUPATIONAL DISEASE OR INJURY ARISING IN THE COURSE OF EMPLOYMENT? ☐ YES ☐ NO DATE OF ONSET OR INJURY:	HAS EMPLOYEE RETURNED TO WORK ON A PART-TIME OR LIGHT DUTY BASIS? ☐ YES ☐ NO IF YES, DATE OF LIGHT/PARTIAL DUTY RETURN:

IS THE EMPLOYEE OFF WORK SOLELY DUE TO REQUIRED, RECOMMENDED, OR SELF-IMPOSED QUARANTINE FOR COVID-19? ☐ YES ☐ NO

IF YES, GIVE DATE THAT EMPLOYMENT IS OR WILL BE AVAILABLE IN ORDER FOR THE EMPLOYEE TO RETURN TO WORK?

EMPLOYER'S SIGNATURE ← SIGN HERE	TELEPHONE NO.	DATE SIGNED
PRINT NAME OF PERSON SIGNING	EMPLOYER ADDRESS	

- Over -

PART 3 - TO BE COMPLETED BY ATTENDING PHYSICIAN

PATIENT NAME	AGE

IS CONDITION DUE TO INJURY OR ILLNESS ARISING OUT OF EMPLOYMENT? ☐ YES ☐ NO	IF YES, PLEASE PROVIDE STATE CASE NUMBER AND INDICATE RELATED DIAGNOSES. STATE CASE NO.: DIAGNOSES:

ICD-10 DIAGNOSIS AND CONCURRENT CONDITIONS	IS CONDITION DUE TO PREGNANCY? ☐ YES ☐ NO EXPECTED DATE OF DELIVERY:
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED:	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION: DATE(S) PATIENT HAS BEEN SEEN FOR THIS CONDITION:
HOW LONG WAS OR WILL PATIENT BE TOTALLY DISABLED (UNABLE TO WORK)? FROM THRU	IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:
HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED? FROM THRU	IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO
DID THE PATIENT'S CONDITION REQUIRE SURGERY? ☐ YES ☐ NO	DATE OF SURGERY:
IF INPATIENT, DATE(S) OF HOSPITALIZATION: ADMIT: DISCHARGE:	IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO

PLEASE LIST THE **NAME, STRENGTH AND DOSAGE** OF THE MEDICATION(S) YOU HAVE PRESCRIBED FOR THE TREATMENT OF THIS PATIENT'S CONDITION(S):

PRINT OR TYPE PHYSICIAN'S NAME AND DEGREE	SOC. SEC. NO. OR TAX ID

STREET ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NO.	FAX NO.

SIGNATURE (ATTENDING PHYSICIAN) **SIGN HERE ➔**	DATE SIGNED

COVID -19 Addition

If the Employee is off work due to quarantine for COVID-19, the Employee must complete Part 1 and Part 4 of this Application.

*PART 4 – TO BE COMPLETED BY THE EMPLOYEE

ARE YOU OFF WORK SOLELY DUE TO YOUR OWN NEED FOR QUARANTINE BASED ON EITHER A PHYSICIAN'S ORDERS, SELF-QUARANTINE DUE TO EXPOSURE, OR YOU ARE IMMUNE-COMPROMISED AND WERE ADVISED TO SELF-QUARANTINE?

☐ YES ☐ NO

IF YES, GIVE DATE QUARANTINE BEGAN:

GIVE DATE YOU RETURNED TO WORK, OR DATE YOU EXPECT TO RETURN TO WORK:

HAVE YOU APPLIED FOR UNEMPLOYMENT INSURANCE BENEFITS? ☐ YES ☐ NO WERE YOU DENIED UNEMPLOYMENT BENEFITS? ☐ YES ☐ NO **IF YOU WERE DENIED UNEMPLOYMENT BENEFITS, SUBMIT A COPY OF THE DENIAL LETTER.**	UNEMPLOYMENT INSURANCE BENEFIT EFFECTIVE DATE:

EMPLOYEE'S SIGNATURE **➔ SIGN HERE**	DATE SIGNED

PRINT NAME	TELEPHONE NO.