NORTHWEST LABORERS-EMPLOYERS HEALTH & SECURITY TRUST
P.O. Box 91002 • Seattle, WA 98111-9102
(206) 282-3600 • (Toll Free) 1-800-826-2102

TIME LOSS REPORT
(Accident and Sickness Weekly Disability Benefit)

INSTRUCTIONS

1. COMPLETE PART I BELOW. 2. HAVE YOUR PHYSICIAN COMPLETE PART II. 3. HAVE YOUR EMPLOYER COMPLETE PART III.
ANSWER ALL QUESTIONS TO INSURE PROMPT PAYMENT. MAIL THE COMPLETED FORM TO THE ADDRESS SHOWN ABOVE.

PART I - EMPLOYEE'S STATEMENT

1. Name (print) _____ Date of Birth _____ ☐Male ☐Female
(First) (Middle Initial) (Last)
2. Address _____
(Number) (Street) (City) (State) (Zip)
3. Social Security # _____ Home Phone (_____) _____ Local Union No._____
4. Employer _____ Employer's Phone _____
5. Date last worked _____ Date returned to work _____ Date you expect to return to work _____
6. On what date did you first receive medical treatment for this condition? _____
Who were you first treated by? _____
7. Describe illness or injury _____
8. Is condition due to injury or illness arising out of ANY employment? Yes ☐ No ☐
If yes, explain _____
9. Are you now receiving Workmen's Compensation for ANY condition? Yes ☐ No ☐
If yes, what condition? _____

IF DISABILITY WAS DUE TO AN ACCIDENTAL INJURY, ANSWER THE FOLLOWING QUESTIONS.

10. Date accident occurred _____ Where did accident occur _____
How did accident occur? _____
Was another person or organization responsible for the injury? Yes ☐ No ☐
If yes, who was responsible? _____

I HEREBY CERTIFY THAT THE FOREGOING STATEMENTS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND HEREBY FURTHER AUTHORIZE MY ATTENDING PHYSICIAN, HOSPITAL, OR DEPARTMENT OF LABOR & INDUSTRIES TO FURNISH AND DISCLOSE ALL INFORMATION REQUESTED BY ZENITH AMERICAN SOLUTIONS.

EMPLOYEE'S SIGNATURE _____ **DATE** _____

PART II - PHYSICIAN'S STATEMENT

Patient's Name _____
1. Diagnosis (Including complications) _____
_____ ICD Code #: _____
Pregnancy? Yes ☐ EDC: _____ No ☐
2. Is condition due to injury or sickness arising out of patient's employment? Yes ☐ No ☐
3. Date symptoms first appeared or accident happened _____
Date patient first consulted you for this condition _____
Frequency of visits _____ Date of most recent visit _____
Is patient still under your care for this condition? Yes ☐ No ☐
4. If hospitalized, date of admission _____ Date discharged _____
Surgical procedure, if any _____ Date performed _____
5. Patient was continuously totally disabled from (start date) _____ to (end date) _____
If still disabled, estimated date patient should be able to return to work _____
6. Name of referring physician _____

PHYSICIAN'S SIGNATURE _____ **DATE** _____
Physician's Name (print or type) _____ Phone No. _____
Address _____
(Number) (Street) (City) (State) (Zip)

PART III - EMPLOYER'S STATEMENT

1. Date employee last worked _____ Date returned to work _____
2. Employee's occupation _____
3. Is this disability due to injury or illness arising out of employment? Yes ☐ No ☐

Employer's firm name _____ Phone No. _____
CERTIFIED BY (print or type name) _____ **(signature)** _____
TITLE _____ **DATE** _____