

# Self-Contribution Coverage Certificate of Disability

## Carpenters Health and Security Trust of Western Washington

- Please complete Part A of this application.
- The attending physician must complete Part B.
- The completed application must be received by the Trust Office by the end of this month.

**PART A: TO BE COMPLETED BY PARTICIPANT**      **DATE:**

<b>Participant's Name: Last, First, Middle</b>		<b>Social Security Number:</b>		
_____		_____		
<b>Patient's Name: Last, First, Middle</b>		<b>Sex:</b>	<b>Date of Birth:</b>	
_____		_____	_____	
<b>Home Address:</b>	<b>Street</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
_____	_____	_____	_____	_____

1. Beginning date of illness or injury: \_\_\_\_\_

2. Nature of illness or injury: \_\_\_\_\_

3. If injury, describe how and where accident occurred: \_\_\_\_\_

\_\_\_\_\_

4. Is condition due to an illness or injury arising out of employment  Yes  No

5. Are you now totally disabled and unable to work  Yes  No

State briefly your present daily activities: \_\_\_\_\_

\_\_\_\_\_

6. When did you become disabled (exact date)? \_\_\_\_\_

7. What physicians have you consulted during your present disability (names, addresses and dates treated)? \_\_\_\_\_

\_\_\_\_\_

8. On what date do you expect your disability to end? \_\_\_\_\_

9. Have you ever had the same kind of illness or injury before  Yes  No

Treated by whom? \_\_\_\_\_

I hereby request and authorize any hospital, physician or other provider who has attended or examined me to furnish to this plan's representative any and all information concerning any illness or injury, medical history, or treatments and copies of all hospital or medical records that same may be included as a part of the proofs of loss submitted by me to the Trust Office. A photostat of this authorization shall be considered as effective and valid as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***PART B. ATTENDING PHYSICIAN'S STATEMENT***  
***(Must be completed in full at no expense to the Trust Office)***

<b>Patient's Name: Last, First, Middle</b>	<b>Sex:</b>
_____	_____
<b>Social Security Number:</b>	<b>Date of Birth:</b>
_____	_____

1. Nature and origin of  Illness  Injury Diagnosis and prognosis (describe complications, if any): \_\_\_\_\_  
\_\_\_\_\_
2. Date symptoms first appeared or date of injury: \_\_\_\_\_
3. When did patient first consult you for this condition? \_\_\_\_\_
4. Is this condition work related?  Yes  No \_\_\_\_\_
5. Describe any other disease or complications affecting present condition: \_\_\_\_\_  
\_\_\_\_\_
6. Date and nature of surgical or obstetrical procedure, if any (describe fully and five approach used if more than one): \_\_\_\_\_  
\_\_\_\_\_
7. Give all dates of treatment and nature of treatment other than surgical: \_\_\_\_\_  
\_\_\_\_\_
8. If maternity, give estimated date of delivery: \_\_\_\_\_  Normal  C-Section
9. If patient is hospitalized, give name and address of hospital and dates: Hospital: \_\_\_\_\_  
Address: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_
10. Is patient under your care for this condition?  Yes  No (If discharged, give date and degree of recovery): \_\_\_\_\_  
\_\_\_\_\_

11. Is patient under the care of another physician?  Yes  No (If yes, provide name and address of physician): \_\_\_\_\_

12. How long was or will patient be continuously disabled?

From \_\_\_\_\_ To \_\_\_\_\_

In his or her occupation From \_\_\_\_\_ To \_\_\_\_\_

In any occupation From \_\_\_\_\_ To \_\_\_\_\_

13. Date patient can return to work: \_\_\_\_\_

14. How long was or will patient be totally disabled?

From \_\_\_\_\_ To \_\_\_\_\_

15. In your opinion, is patient a candidate for rehabilitation:  Yes  No

16. Does patient have a life expectancy of 12 months or less?  Yes  No

Remarks: \_\_\_\_\_  
\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Title \_\_\_\_\_

Name (please print) \_\_\_\_\_

Address \_\_\_\_\_  
Number Street City State Zip

Date \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_