

# WEEKLY INCOME / DISABILITY WAIVER APPLICATION

RETURN THIS FORM TO:

COMPLETE AS FOLLOWS:

PART I EMPLOYEE  
PART II EMPLOYER  
PART III PHYSICIAN

## NORTHWEST ADMINISTRATORS, INC.

2323 EASTLAKE AVE EAST SEATTLE, WASHINGTON 98102-3393

CLAIMS/BENEFITS ONLY: (206) 726-3277 Or 1-800-458-3053 ELIGIBILITY/OTHER: (206) 329-4900

### 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	<input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED	<input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED
CITY, STATE, ZIP CODE			SOCIAL SECURITY NO.	LOCAL UNION NO.	HOME TELEPHONE NO.	
DID YOUR WORK CAUSE THIS CONDITION?	<input type="checkbox"/> YES <input type="checkbox"/> NO	HAS A CLAIM BEEN FILED WITH THE WORKER'S COMPENSATION CARRIER?	<input type="checkbox"/> YES <input type="checkbox"/> NO	FIRST DAY UNABLE TO WORK DATE _____ HOUR _____	IF YOU HAVE RETURNED TO WORK, GIVE DATE OF RETURN	
IF CLAIM IS FOR AN INJURY, YOU MUST COMPLETE THIS SECTION	DATE OF INJURY	TIME	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	WERE YOU AT WORK WHEN INJURED? <input type="checkbox"/> YES <input type="checkbox"/> 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	DATE SIGNED
<b>X</b>	<b>← SIGN HERE</b>

### PART II - TO BE COMPLETED BY THE EMPLOYER

DATE EMPLOYED	FIRST FULL DAY UNABLE TO WORK	DATE RESUMED WORK	DATE EXPECTED TO RESUME WORK
IS THIS DISABILITY THE RESULT OF OCCUPATIONAL DISEASE OR INJURY ARISING IN THE COURSE OF EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF YES, GIVE DATE OF ONSET OR INJURY			
EMPLOYER'S SIGNATURE	TELEPHONE NO.	DATE SIGNED	
PRINT OR TYPE	NAME OF PERSON SIGNING		

### PART III - TO BE COMPLETED BY ATTENDING PHYSICIAN

PATIENT NAME	AGE	IS CONDITION DUE TO INJURY OR ILLNESS ARISING OUT OF EMPLOYMENT?	<input type="checkbox"/> YES <input type="checkbox"/> NO
DIAGNOSIS AND CONCURRENT CONDITIONS (OR I.C.D.A.)	IS CONDITION DUE TO PREGNANCY?	EXPECTED DATE OF DELIVERY	<input type="checkbox"/> YES <input type="checkbox"/> NO
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION		
PATIENT WAS CONTINUOUSLY DISABLED (UNABLE TO WORK)	IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK		
<input type="checkbox"/> YES <input type="checkbox"/> NO			
FROM	THRU		
DATE(S) PATIENT HAS BEEN SEEN FOR THIS CONDITION	IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO		
PRINT OR TYPE PHYSICIAN'S NAME AND DEGREE	SOC. SEC. NO. OR TAX ID		
STREET ADDRESS	CITY	STATE	ZIP CODE
SIGNATURE (ATTENDING PHYSICIAN)	TELEPHONE NO.	DATE	
<b>X</b>			