PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

# Writers' Guild-Industry Health Fund

Jim Hedges, Chief Executive Officer

## HEALTH FUND TOTAL DISABILITY APPLICATION FORM

***TO AVOID DELAY BE SURE ALL QUESTIONS ARE ANSWERED COMPLETELY***

**Date:** _____

***This section is to be completed by the Participant***

_____ _____ _____

**Participant's Last Name** **First Name** **MI** **Alternate ID#**

_____ (___)_____

**Address** **City** **State** **Zip Code** **Telephone**

Person Totally Disabled at the time coverage ended: _____

☐ Participant ☐ Dependent **Date of Birth:** _____

**Describe in details what caused the patient's injury/disability. If you need additional space attach your statement to the back of this form.**

_____

_____

_____

Was the patient confined to the hospital? ☐ Yes ☐ No. Date of confinement:_____

Give first date treated for this injury/disability: _____ Is this work related? ☐ Yes ☐ No

Last date of work___/___/___ Date you expect to return to work___/___/___

Are you receiving benefits as a result of this injury/disability? ☐Yes ☐No

**If yes, please indicate type below:**

| SOURCE | | DATE BENEFIT BEGAN |
|---|---|---|
| State Disability | ☑ | |
| Social Security | ☐ | |
| Federal /State | ☑ | |
| Worker's Compensation | ☐ | |
| Pension | ☐ | |
| Other | ☐ | |

Name of Attending Physician:

_____ ( )

Physician's Name Address City Zip Code Telephone

PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

# ATTENDING PHYSICIAN'S STATEMENT

*THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY.*

**USE SECOND PAGE OF THIS FORM FOR ADDITIONAL COMMENTS**

Name of patient _____ Date of birth _____
Mo./Day/Year

Participant's Name_____ Participant's ID#._____

## 1. History

**(a)** When did symptoms first appear or accident happen? Mo._____ Day_____ Year_____

**(b)** Date patient ceased work because of disability Mo. _____ Day _____ Year _____

**(c)** Has patient ever had same or similar condition? Mo. _____ Day _____ Year _____

☐ Yes ☐ No

If "Yes" state when and describe

**(d)** Is condition due to injury or sickness arising out of patient's employment? ☐Yes ☐No ☐Unknown

**(e)** Names and addresses of other attending physicians_____

_____

## 2. DIAGNOSIS (including any complications)

**(a)** Date of last examination Mo._____ Day _____ Year _____

**(b)** Diagnosis (including any complications)

**(c)** Subjective symptoms

**(d)** Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)

## 3. DATES OF TREATMENT

**(a)** Date of first visit Mo. _____ Day _____ Year _____

**(b)** Date of last visit Mo. _____ Day _____ Year _____

**(c)** Frequency ☐Weekly ☐Monthly ☐Other (Specify)

## 4. NATURE OF TREATMENT

## 5. PROGRESS

**(a)** Has patient ☐Recovered ☐Improved ☐Unchanged ☐Retrogressed

**(b)** Is patient ☐Ambulatory ☐House Confined ☐Bed Confined ☐Hospital Confined

Has patient been hospital confined? ☐Yes ☐No If yes, give the Name and Address of Hospital _____

_____ Confined From _____ Through _____

## 6. IMPAIRMENT (*As Defined In Federal Dictionary of Occupational Titles)

☐ Class 1 – No limitation of functional capacity; capable of heavy work* No restrictions (0-10% limitation)
☐ Class 2 – Medium manual activity (15-30% limitation)
☐ Class 3 – Slight limitation of functional capacity; capable of light work* (35-55% limitation)
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)
☐ Class 5 – Servere limitation of functional capacity; incapable of minimal (sedentary*) activity (75-100%)

Remarks:

## 7. MENTAL/NERVOUS IMPAIRMENT (If Applicable)

**(a)** Please define "stress" as it applies to this claimant

**(b)** What stess and problems in interpersonal relations has claimant had on job?

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)

☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relatations (slight limitations)

☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)

☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)

☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (servere limitations)

Remarks:

## 8. PROGNOSIS

| | | PATIENT'S JOB | ANY OTHER WORK |
|---|---|---|---|
| **(c)** | Is patient now totally disabled? | ☐ Yes ☐ No | ☐ Yes ☐ No |

**(d)** What duties of patient's job is he/she incapable of performing?

Do you expect a fundamental or marked change in the future? ☐ Yes ☐ No

(1) If yes, when will patient recover sufficiently to perform duties? ___/___/____ ☐ 1 mo. ☐ 1-3 Mos ☐ 3-6 Mos ☐ Never

(2) If no, please explain _____

_____

## 9. REHABILITATION

**(e)** Is patient a suitable candidate for further rehabilitation services (i.e. cardiopulmonary program, speech therapy, etc.)? ☐ Yes ☐ No

**(f)** Can present job be modified to allow for handling with impairment? ☐ Yes ☐ No

| | | PATIENT'S JOB | ANY OTHER WORK |
|---|---|---|---|
| **(c)** | When could trial employment commence? | ☐ Full Time ☐ Part Time | ☐ Full Time ☐ Part Time |
| | | **Mo. Day Yr.** | **Mo. Day Yr.** |

**(d)** Would vocational counseling and/or retraining be recommended? ☐ Yes ☐ No

## 10. REMARKS

**Name (Attending Physician) Print** **Degree** **Telephone**

**Street Address** **City or Town** **State or Province** **Zip Code**

**Signature** **Date**