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

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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**