SEATTLE AREA PLUMBING & PIPEFITTING INDUSTRY HEALTH TRUST

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APPLICATION FOR EMPLOYEE WAIVER OF PREMIUM

Patient's Name: _____
Address: _____
Social Security Number: _____ Date of Birth: _____

NOTE: THIS PORTION MUST BE COMPLETED BY THE PARTICIPANT'S PHYSICIAN

I History and Condition

(a) When did present illness/injury begin? _____

(b) Date patient was obligated to cease work _____

(c) Date first treated by you _____ Last treated _____

(d) Anticipated future treatment: _____

(e) Is patient ambulatory or bed, house, hospital confined? _____

II Diagnosis (Describe fully the injury or disease-causing present disability. Use additional paper if necessary or attach copy of Medical Report.)

_____
_____
_____

III Degree of Disability

(a) Has patient been able to do any work? ☐ Yes ☐ No
If yes, from what date _____ Type of work? _____

(b) If not, when do you think the patient will be able to do any work?

_____

_____
**Physician's Signature Medical Specialty Date
**(NO FACSIMILE WILL BE ACCEPTED)

Physician's name and address (Please print):

_____
_____
_____

NOTE: THIS PORTION TO BE COMPLETED BY THE PARTICIPANT

I have been unable to work since _____ and therefore request that my monthly premium be waived in accordance with the provisions of the Health & Welfare Plan, for up to a maximum of 6 months.

I understand it is my responsibility to inform the trust office when I have been released by the doctor for work

_____ _____
Member's Signature Telephone Number Date