Masonry Welfare Trust Fund
9848 E BURNSIDE
PORTLAND OR 97216
(503) 254-4022 (503) 254-4119 fax
Toll Free: 1 800 591-8326

DISABILITY WAIVER APPLICATION

Please complete the "Employee" section, have your physician complete the "Physician" section, and promptly return to the address at the left.

Employee Information

Soc. Sec.# _____

Name: _____

Check One:

This is the first time I'm submitting this form ☐

I am submitting an **update** on my disability ☐

Date last worked_____

Have you returned to work_____
If yes, on what date_____

I understand that there are *a limited number of Disability Wavers available per disability* and I authorize the Trust Office to apply all applicable waivers based on the information supplied by my physician.

_____
Signature of Participant Date

Please have your **physician** complete the bottom portion. Please return to the Trust Office at the above address.

Physician Information

I certify I attended_____ Age_____

Is disabled due to (circle one): Worker's Compensation or Accident/Injury or Illness

Diagnosis:_____

Date of first medical treatment:_____ Date of last Medical treatment:_____

Nature of surgical or obstetrical procedure, if any (describe fully):_____

Where performed:_____ Date:_____

The patient has been continuously disabled (unable to work) from:_____ **Through**:_____

If released to "light duty" what is date released and restrictions:_____

When should patient be able to return to un-restricted work (*please estimate if exact date unknown*):_____

Remarks:_____

_____

Name of attending physician print): _____Date: _____

Clinic/Facility Name: _____

Address:_____

Attending physician (signature): _____ Phone:_____ Fax: _____

Masonry Welfare Trust

Application for Temporary Disability Benefits

9848 East Burnside
Portland, OR 97216
1-800-591-8326 or 503- 254-4022

Section I – Must be completed by Employee

Name:_____Social Security Number:_____

Full Address:_____

Phone Number:_____

Please complete each of the following:

A. Are you receiving, eligible for, or will you be applying for: (Please enter mm/dd/yy)

1. Workmen's Compensation ☐ If receiving, start & end date_____ to _____
2. Unemployment ☐ If receiving, start & end date_____ to _____
3. Retirement ☐ If receiving, start date_____

B. Are you receiving any other compensation? Yes ☐ No ☐
If Yes, please attach information

C. Is the disability due to your employment? Yes ☐ No ☐

D. Is the disability due to an accident of any kind? Yes ☐ No ☐
If yes, please advise how, when & where the accident occurred:

_____

_____

E. Is the disability the result of negligence or the intentional act of a third party? Yes ☐ No ☐
If yes, please advise how, when & where the accident occurred:

_____

_____

F. Are, or were you, ever hospitalized due to this disability? Yes ☐ No ☐
*If yes, what dates?*_____

G. Are you currently working? Yes ☐ No ☐ Last date you worked: (Please enter mm/dd/yy)

H. Please list name, address and phone number of your most recent employer:

_____

_____

I. Are you still disabled? Yes ☐ No ☐

I AM APPLYING FOR:
Temporary Disability Income Benefits ☐ Disability Waiver of Premium ☐ Both ☐

Signature of Employee_____Date_____

Continued on back... →

Section II – Must be completed by attending Physician

1. What is the disabling diagnosis code:_____

   _____

2. Date employee first consulted you for this condition:_____
3. Date of last treatment:_____
4. Frequency of treatment and/or next scheduled treatment:_____
5. Dates of total disability: (Please enter mm/dd/yy) From:_____ through _____

   (If return to work date is unknown, please estimate. This may be revised later)

6. Please cite the clinical evidence which prevents the employee from working:

   _____

   _____

Physician's Signature:_____Date:_____

Physician's Name, address & Phone number:_____

_____

Masonry Welfare Trust

Application for Temporary Disability Benefits

9848 East Burnside
Portland, OR 97216
1-800-591-8326 or 503- 254-4022

Name:_____Social Security Number:_____

Full Address:_____

Phone Number:_____

Must be completed by most recent Employer

The Employee listed on this form is applying for TEMPORARY DISABILITY benefits through the Masonry Welfare Trust. Please answer the following questions and return this form so we may process the disability claim. If you have any questions, please contact the Masonry Welfare Trust, claims department @1-800-591-8326, or 503-254-4022.

1. Is the employee receiving any paid compensation? Yes ☐ No ☐
   *If yes, what type:*_____
   For what dates: From _____ *to* _____

2. If this is a work related claim, for which of the following could the employee apply?
   1. Workmen's Compensation ☐
   2. Unemployment ☐

4. Is the employee currently working? Yes ☐ No ☐

   *If yes, when did the employee return to work*_____

Signature of employer representative completing form:_____

Please print your name:_____Title:_____Date:_____

Name of Company:_____Phone number:_____

Return this form to: Masonry Welfare Trust, 9848 E Burnside, Portland, OR 97216 / Fax: 503-254-4119

MASONRY INDUSTRY TRUST
ADMINISTRATION
9848 E Burnside Street
Portland OR 97216
(503) 254-4022 Fax: (503) 255-4073
Toll Free: 1 800 591-8326

MASONRY WELFARE TRUST FUND

Temporary Disability Benefit – Direct Deposit Form

The Trust Office will electronically deposit your Temporary Disability Benefit payment directly to your checking account. **A copy of your Explanation of Benefits will be emailed to you**.

To have your payment deposited to your account, please complete the information below and return to the Trust Office along with a voided check.

I authorize the Masonry Welfare Trust Fund to automatically deposit my Temporary Disability benefit payment into my account listed below. (This includes authorizations to correct any entries made in error.) This authorization will remain in effect until I give written notice to cancel it.

Signature of Participant **Date**

Social Security Number **Phone Number**

E-Mail Address (Required)

Attach Voided Check Here. ***Do not send Deposit Slip as they frequently use different routing numbers.***

Name of Bank or Financial Institution **Phone #**

Address

Routing # **Account #**

Important: ***Your name must be on any account that you are having your benefit check deposited to.***

Return Form to: Masonry Welfare Trust Fund
9848 E Burnside St, Portland OR 97216