Vaccine Incentive Claim Form

ALASKA LABORERS HEALTH AND SECURITY FUND

P. O. Box 34567, Seattle, WA 98124-1567
claimstatus@wpas-inc.com and Fax 206-441-9110

Instructions:

This form must be completed and Part IV signed off by the attending physician if requesting a waiver of proof of full vaccination. Please complete this form and send to the Administration Office at the address listed above.

For Toll-Free Assistance Nationwide Call:
Welfare & Pension Administration Service, Inc.
Claims Office 1-855-815-2323

PART I - EMPLOYEE DATA:

Employee Name:_____ ID or Social Security No.: _____
(First Name) (Last Name)

Mailing
Address:_____
(Street) (City) (State) (Zip)

PART II - PATIENT DATA: Claim is for: ☐ Employee ☐ Spouse ☐ Dependent Child

Patient Name:_____ Birth Date: _____/_____/_____
(First Name) (Last Name)

PART III - VACCINE PROOF:

DID YOU RECEIVE FULL VACCINATION? (both shots if it is a 2-shot series) ☐ YES, DATE: _____	WHAT KIND OF DOCUMENTION WILL BE SUBMITTED? ☐ VACCINE CARD ☐ OTHER PROVIDER RECORDS. PLEASE PROVIDE PROOF OF VACCINATION ALONG WITH THIS FORM FOR PROCESSING

PART IV - PHYSICIAN STATEMENT (ONLY COMPLETE IF REQUESTING MEDICAL WAIVER):

PATIENT'S NAME	AGE
IS THE PATIENT REQUESTING A WAIVER FOR MEDICAL REASONS? YES ☐ NO ☐ IF YES, PLEASE PROVIDE A BRIEF DESCRIPTION OF REASON COVID-19 VACCINATION IS NOT PERMITTABLE: _____ _____ _____ _____ _____	
DATE PHYSICIAN'S NAME (PRINT) SIGNATURE DEGREE TELEPHONE	
STREET ADDRESS CITY – STATE – ZIP CODE _____ _____ _____	INDIVIDUAL PRACTITIONERS TIN OR SS# NPI

PART V - AUTHORIZATION TO PROCESS CLAIM:

In order to process the vaccine incentive application, I authorize any physician, hospital or other medical provider to release to Welfare & Pension Administration Service, Inc. (WPAS) and the planholder, or their representatives, any information regarding my and/or my dependent's health history, symptoms, treatment, examination results or diagnosis. This authorization shall be considered valid for the duration of the application. ***Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.***

_____ _____/____/_____
Eligible Participant's Signature Date