WEA trust

P.O. BOX 259537
MADISON, WI 53725-9537
FAX 608.276.9119
CUSTOMER CONTACT CENTER 800.279.4000

Application For Long Term Care Benefits

Complete all sections of this form. Please complete electronically or print (use either black or blue ink) and return the completed form to WEA Trust at the address listed above.

Claimant's Name:	Phone No.: Date of Birth:
Claimant's Address:	Social Security No.: Subscriber No.: Marital Status: (Select One)
Covered Employee/Retiree Name (if different from above):	Phone No.:
Covered Employee/Retiree Address (if different from above):	Subscriber No.:
Contact Person Name:	Phone No.:
Contact Person Address:	Relationship to Claimant:

1. Medical condition/diagnosis:

2. How does your condition limit your physical or mental ability to perform the activities of daily living listed on the attached "Definitions" page? (Attach separate sheet if necessary)

3. Date symptoms began:

4. Date first treated for this condition:

5. Is your condition/injury the result of an accident? ☐ Yes ☐ No
   If yes, did the condition/injury arise out of your employment? ☐ Yes ☐ No

   Please provide information regarding how, when, and where accident occurred.
   (Attach separate sheet if necessary and accident report if applicable)

6. Are you presently receiving any of the following? Please check the appropriate boxes and identify the provider(s).

	Provider Name	Telephone Number
☐ Skilled Nursing Care	______	______
☐ Home Health Care	______	______
☐ Adult Day Care	______	______
☐ Nursing Home Care	______	______
☐ Hospice	______	______
☐ Assisted Living	______	______

7. Indicate which medical equipment you currently use:

☐ Grab bars ☐ Raised toilet seat ☐ Cane (quad or white) ☐ Walker
☐ Hospital bed ☐ Trapeze ☐ Commode
☐ Wheelchair (specify manual, electric, or mechanized scooter) ______
☐ Other (please describe) ______

8. Are you covered under any other group health and/or group long term care insurance policies in addition to those with WEA Insurance? If so, please check which type and complete the requested information.

Group Health Insurance ☐ Yes ☐ No

Company Name: ______
Company Address: ______
______
Policyholder's Name: ______
Policy No.: ______ Effective Date: ______

Group Long Term Care Insurance ☐ Yes ☐ No

Company Name: ______
Company Address: ______
______
Policyholder's Name: ______
Policy No.: ______ Effective Date: ______

Medicare ☐ Yes ☐ No

Company Name: ______
Company Address: ______
______
Policyholder's Name: ______
Policy No.: ______ Effective Date: ______

Medicaid ☐ Yes ☐ No

Company Name: ______
Company Address: ______
______
Policyholder's Name: ______
Policy No.: ______ Effective Date: ______

9. Treating Physician's Name: ____________________

Office Address: ____________________ Telephone No.: ____________________

City: ____________________ State: __________ Zip Code: __________

(Attach separate sheet if necessary to report additional physicians and their addresses)

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10. Do you have a Power of Attorney, Durable Power of Attorney, Conservator, or Guardian? ☐ Yes ☐ No

If yes, please provide:

Name: ____________________

Address: ____________________ City: ____________________ State: ______ Zip: __________

Phone: ____________________

I declare that all of the above answers are complete and true to the best of my knowledge and belief. I understand that WEA Trust reserves the right to require further proof.

____________________ ____________________

Signature of Claimant (or Claimant's Representative) Date signed (Month, Day, Year)

____

Claimant (or Claimant's Representative) Name (Please Print)

____

If Representative, give relationship to Claimant

Return completed form to:

WEA Trust

P.O. BOX 259537

MADISON, WI 53725-9537

Definitions

Activities of Daily Living (ADLs) are Bathing, Continence, Dressing, Eating, Toileting, and Transferring as defined herein.

- Bathing means washing oneself by sponge bath or in either a tub or shower, including the task for getting into or out of the tub or shower, without Substantial Assistance from another person.
- Continence means the ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag, without Substantial Assistance from another person.
- Dressing means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs without Substantial Assistance from another person. An individual will be considered able to dress himself or herself even if these tasks can only be performed by using modified clothing or adaptive devices such as tape fasteners or zipper pulls.
- Eating means feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously without Substantial Assistance from another person. An individual will be considered able to eat even if he or she requires assistance preparing or serving the food, such as cutting food or opening cartons.
- Toileting means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene without Substantial Assistance from another person.
- Transferring means the ability to move into or out of a bed, chair, or wheelchair without Substantial Assistance from another person. An individual will be considered able to transfer even if he or she uses or requires equipment such as canes, quad canes, walkers, crutches, grab bars, or other support devices, including mechanical or motorized devices, in order to transfer or ambulate.

Substantial Assistance means Hands-on Assistance or Standby Assistance.

- Hands-on Assistance means the physical assistance of another person without which the Chronically Ill individual would be unable to perform the Activities of Daily Living.
- Standby Assistance means the presence of another person within arm's reach of the Chronically Ill individual that is necessary to prevent, by physical intervention, injury to the Chronically Ill individual while he or she is performing an Activity of Daily Living.

Substantial Supervision means continual supervision (which may include cuing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Severely Cognitively Impaired individual from threats to his or her health or safety (such as may result from wandering).

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800.279.4000 WEAtrust.org

Submitting Forms and Correspondence to WEA Trust

To make filling out forms easier, some of our forms are fillable PDFs which allow you to complete and then save the form on your computer or device. Depending on the browser you are using you may or may not not be able to use this feature.

Fillable PDFs require Adobe Acrobat or Acrobat Reader/Acrobat DC to fill them out online or on your computer. Many browsers use a different PDF viewer by default that doesn't support fillable form fields.

If you are unable to complete the forms on your computer or device, you may be able to download and save them to your computer and then fill them out. If you are unable to complete the forms on your computer or device or are unable to download the forms, please feel free to call us at **800.279.4000** and we will be happy to mail you paper copies.

Don't forget to save your work to your computer or device often.

You can submit forms and correspondence to us in whatever way works best for you …

Postal Service

Address your envelope to:
WEA Trust
PO Box 259537
Madison, WI 53725-9537

Fax

Include your name and Subscriber Number on the cover page of your fax and send to:
608.276.9119

Secure File Upload

Send scanned or electronically completed forms to us via our www.weatrust.org website at:
https://weatrust.org/secure-file-upload-1

Email

Attach your scanned or electronically completed forms to an email and send to us at:
customerservice@weatrust.org

Refer to your Benefit Summary and Plan Document for specific benefit information. If you have any questions, we encourage you to call us at **800.279.4000**.

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Provider Certification

Claimant Name:	Social Security No.:
	Subscriber No.:
	Date of Birth:

I assessed the condition of the above-named person on ______________________
Date

He/She has a diagnosis of ______________________

I certify that the above-named person is in need of long term care services due to either functional incapacity or severe cognitive impairment as described below. Please place a check mark beside either A ***or*** B below and in the appropriate subset of boxes under either A **or** B.

*** * ATTACH A COPY OF THE PLAN OF CARE TO THIS FORM. * ***

☐ A.

☐ Functional Incapacity: This individual is unable to perform the following Activities of Daily Living (ADLs), as defined on the reverse of this page, without substantial assistance from another individual. Please place a check mark in the appropriate boxes.

- ☐ Bathing
  - ☐ Standby
  - ☐ Hands-on
- ☐ Dressing
  - ☐ Standby
  - ☐ Hands-on
- ☐ Toileting
  - ☐ Standby
  - ☐ Hands-on
- ☐ Continence
  - ☐ Standby
  - ☐ Hands-on
- ☐ Eating
  - ☐ Standby
  - ☐ Hands-on
- ☐ Transferring
  - ☐ Standby
  - ☐ Hands-on

AND

☐ This patient's inability to perform the above-noted ADLs has continued and/or is reasonably expected to continue for at least 90 consecutive days. (The calculation of the anticipated 90-day period may include days of hospitalization following the incident causing the current incapacity.)

☐ B.

☐ Severe Cognitive Impairment: This individual has experienced a loss or deterioration in intellectual capacity which:

1) Has been demonstrated by clinical evidence and standardized tests in:
   a) short-term or long-term memory;
   b) orientation as to people, places, or time; and,
   c) deductive or abstract reasoning; and

Please note the test(s) and score(s) that document this individual's cognitive deficits:

☐ SPMSQ: (Date) ___________ ☐ MMSE: (Date) ___________ ☐ Other (specify): ______________

2) Is comparable to Alzheimer's disease and similar forms of irreversible dementia.

AND

☐ Requires Substantial Supervision to protect himself/herself or others from threats to health and safety.

I certify that the above information is a true and accurate representation of the above-named individual's current capacity.

Provider's Name (please type or print): ______________________

Degree: ☐ M.D. ☐ Other: ______________ Specialty: ______________

Name of Clinic: ______________ Address: ______________

City: ______________ State: __________ Zip Code: __________ Phone No.: ______________

Provider's Signature: ______________________ Date: ______________

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Plan of Care

Complete all sections of this form. Please complete electronically, or print (use either black or blue ink) and return the completed form to WEA Trust at the address listed above.

Claimant Name:	Subscriber No.:
	Date of Birth:

1. What type of long term care services are recommended? (Please check all that apply.)

☐ Nursing Facility
☐ Home Health Care
☐ Alternate Care Facility
☐ Adult Day Care
☐ Hospice
☐ Respite Care
☐ Other (Please explain) ______________________________

2. Based on your clinical assessment, what specific care will the above-named individual require (e.g., standby or hands-on assistance with feeding, ambulation, medication administration, ensuring safety)?:

3. How long do you anticipate the above-named individual will require services?

I certify that the above information is a true and accurate representation of the above-named individual's current capacity.

Provider's Name (please type or print): ______________________________

Degree: ☐ M.D. ☐ Other: ______________ Specialty: ______________

Name of Clinic: ______________________________ Address: ______________

City: ______________ State: __________ Zip Code: __________ Phone No.: ______________

Provider’s Signature: ______________________________ Date: ______________