

Central Laborers' Pension Fund
Proof of Disability Form
For Non-Work Disability Pension Credit

Instructions: The Pension Plan provides Non-Work Disability Pension Credit to Laborers who are unable to perform their usual occupational duties as a result of a disability. Please have your Doctor complete the Physician's Statement on the reverse side.

Employee's Statement

Name _____ Social Security Number _____
 Last First Middle

Address _____
 Street City State Zip Code

Birth Date _____ Local Union No. _____ Initiation Date _____

Type of Disability: (Check one and complete the requested information)

• **Occupational Disability**

1. Disability due to: _____

2. Period of disability from _____ to _____
 Month/Day/Year Month/Day/Year

I received Worker's Compensation from _____ to _____ as a
 Month/Day/Year Month/Day/Year
result of the on-the-job disability described above and documents substantiating my Worker's
Compensation award for the period shown are attached.

• **Non-Occupational Disability**

1. Non-Occupational Disability due to Accident Sickness

2. Description of disability _____

3. Period of disability from _____ to: _____
 Month/Day/Year Month/Day/Year

4. Date of first doctor's treatment _____
 Month/Day/Year

Your doctor's statement as to the nature of your disability must be included on the form provided on the reverse side of this application, regardless of whether you are applying for occupational or non-occupational disability.

I hereby apply for Non-Work Disability Pension Credit based on the proof submitted herein. I have provided all of the required information about my occupational or non-occupational disability and I certify that the information is true and correct. I also request and authorize my physician to complete this form and submit the information to the Pension Fund.

Date

Employee Signature

Statement of the Attending Physician

Name of Employee : _____ Phone Number _____

Present Address: _____
Street City State

History:

- Disability due to Illness Injury due to accident
- When did present illness begin, or injury occur? _____
Month/Day/Year
- Date employee was obliged to cease work? _____
Month/Day/Year
- Patient has been continuously disabled (unable to work) from _____ to _____
Month/Day/Year Month/Day/Year
- Is there a previous history of this illness? Yes No
- Did sickness or injury arise out of patient's employment? Yes No If "yes" please explain

Diagnosis:

Treatment:

- Date of first visit _____ (Month/Day/Year)
- Date of last visit _____ (Month/Day/Year)
- Frequency of visits _____
- When did you last examine the Employee? _____ (Month/Day/Year)
- When do you recommend reexamination? _____ (Month/Day/Year)

Progress:

- | | | | |
|--------------------------|-----------|--------------------------|--------------|
| <input type="checkbox"/> | Recovered | <input type="checkbox"/> | Unimproved |
| <input type="checkbox"/> | Improved | <input type="checkbox"/> | Retrogressed |

Degree of Disability:

- Has the Employee been able to perform any work; if so, from what dates?

Regular Work as a Laborer _____ Other Work _____
Month/Day/Year Month/Day/Year

- If not, when do you think he/she will be able to work?

- Approximate date _____ (Month/Day/Year)
- Indefinite
- Never

(please print)

Doctor's Name _____ Telephone _____
Address _____

Signature _____ M.D. _____
Date _____