Central Laborers' Welfare Fund

Proof of Disability Form
For Non-Work Disability Welfare Credit

Instructions: The Welfare Plan provides Non-Work Disability Welfare 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 Welfare 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 Welfare 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:

☐ Recovered ☐ Unimproved
☐ Improved ☐ 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 ____

____M.D. ___________________________
Signature Date