CENTRAL PENSION FUND OF THE INTERNATIONAL UNION OF OPERATING ENGINEERS & PARTICIPATING EMPLOYERS
4115 Chesapeake Street, NW, Washington, DC 20016 Tel(202) 362-1000; Fax (202) 364-2913

# STATEMENT FOR PERMANENT AND TOTAL DISABILITY BENEFITS

## Section I: PARTICIPANT INFORMATION

You must complete this form in its entirety, and your attending physician must complete the reverse side of this form. Incomplete Statements will be returned, delaying the processing of your claim.

Name: ____________________ Social Security No.: ____________

Address: ____________________ Telephone No.: ____________

City: ____________________ State: __________ Zip: __________

Date of Birth: ____________ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Have you been awarded disability benefits by the Social Security Administration? ☐ Yes ☐ No

Note: If your answer is No and you are applying for Disability benefits from the Central Pension Fund, attach a copy of the Disability Report (Form SSA 3368-BK) you filed with the Social Security Administration. Disability Benefits will not begin until you receive and forward a copy of the Notice of Award of Disability Benefits from the Social Security Administration. If your answer is Yes please attach a copy of your Notice of Award of Disability from the Social Security Administration as well as a copy of the Disability Report you filed with the Social Security Administration, and complete the remainder of this Statement.

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Date of your disability or the date you first noticed the symptoms of your illness: ____________

Date you returned to work on a part-time basis: ____________

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Date you stopped working: ____________

Date you returned to work on a full-time basis: ____________

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What is your disability condition? (Briefly explain the injury or illness that stops you from working.)

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Describe how and where the disability occurred or describe the first symptoms of your illness.

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What licensed physicians have treated you since the beginning of this disability?

| Name | Address | Date of Treatment |
|---|---|---|
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In what hospitals or other institutions were you confined since the beginning of this disability?

| Name | Address | Date of Treatment |
|---|---|---|
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The above statements are true and complete to the best of my knowledge and belief, and I hereby authorize any hospital or physician who has treated me, or other person who has attended me or examined me, or any company or governmental agency to furnish the Central Pension Fund, as agents, any and all information with respect to any illness, injury, medical history, consultations, prescriptions, treatments or benefits, and copies of all applicable records.

______________________________ ______________________________

Applicant Signature Date

Patient Name: ______________________________ Social Security No.: ______________

The Patient is responsible for the completion of this form without expense to the Fund.

SECTION II: ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY
All sections must be completed by a licensed physician.

1. History
(a) When did symptoms first appear?

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(b) Date patient ceased to work because of disability.

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(c) Has patient ever had same or similar condition?
If yes, state when and give a brief description. Yes ☐ No ☐

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Name and address of other attending physicians:

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2. Treatment
(a) Date of first visit: ______________________________

(b) When did you last examine the patient? ______________________

(c) Date of most recent visit: ______________________________

(d) Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other

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3. Diagnosis (including subjective symptoms, objective finding, and any complications):

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4. Nature of treatment (including surgery and medications prescribed, if any):

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5. Progress:

a) Has patient ☐ Recovered? ☐ Improved? ☐ Unchanged?

b) Is patient ☐ Ambulatory? ☐ House Confined? ☐ Bed Confined?

c) Has patient been hospital confined? ☐ Yes ☐ No

If yes, give name and address of hospital:

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Confined from: ______________________ through ______________________

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6. Prognosis:
Is the medical condition described in Section 3 above expected to be permanent and not subject to improvement by any known medical treatment or procedure? ☐ Yes ☐ No

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7. Attending Physician:

Name: ______________________________ Telephone: ______________________

Address: ______________________________________________________________

City: ______________________ State: ______________ Zip: ____________

Signature: ______________________________ Date: ______________________

Degree: ______________________________

Attention to Physician:
In order to be eligible for Disability Benefits, a participant must be totally disabled based upon a physical or mental condition resulting from bodily injury, disease, or mental disorder. In addition, such disability is expected to be permanent and cannot be improved by any known medical treatment procedures.