



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.

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: \_\_\_\_\_
Date you stopped working: \_\_\_\_\_ Date you returned to work on a full-time basis: \_\_\_\_\_

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

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

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

Table with 3 columns: Name, Address, Date of Treatment

In what hospitals or other institutions were you confined since the beginning of this disability?

Table with 3 columns: Name, Address, Date of Treatment

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:

\_\_\_\_\_  
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.