

# LOCAL 46 IBEW Retirement Annuity Trust

## Total and Permanent Disability 401(k) Savings Questionnaire

Physical Address 7525 SE 24th Street Suite 200 Mercer Island, WA 98040 • Mailing Address PO Box 34203 Seattle, WA 98124

Phone (206) 441-4667 or (866) 314-4239 • Fax (206) 695-0984 • Website www.psewtrusts.com

Administered by

Welfare & Pension Administration Service, Inc

### EMPLOYEE'S STATEMENT

**NOTE:** Please fill out this questionnaire completely, as all data is pertinent in determining your eligibility for a Disability Pension award from this Fund. Thank you!

1. Employee's Name (Print) \_\_\_\_\_ Social Sec. No. \_\_\_\_\_  
*First Middle Last*

2. Employee's Address \_\_\_\_\_

3. Date you last worked \_\_\_\_\_ Date Disability began \_\_\_\_\_ Phone No. \_\_\_\_\_

4. Please state in your own words the nature of your disability \_\_\_\_\_  
\_\_\_\_\_

5. Have you filed a Claim for Workmen's Compensation? Yes  No  If "Yes", State Claim No. \_\_\_\_\_

6. Have you filed for Social Security Disability? \_\_\_\_\_ Has your claim been approved? \_\_\_\_\_

If so, date of approval \_\_\_\_\_ **Please attach a copy of your Social Security Disability Award Letter**

7. Please list name and address of all hospitals to which you were confined and doctors seen in the past year :

NAME AND ADDRESS OF HOSPITALS	NAME AND ADDRESS OF DOCTORS

8. Are you engaged in any rehabilitation? \_\_\_\_\_ If yes, where? \_\_\_\_\_

9. Have you worked at any occupation since disability commenced? \_\_\_\_\_

a. If yes, please list the name and address of employer and the position you held while employed: \_\_\_\_\_  
\_\_\_\_\_

*Please Note: When returning this form, you may include copies of any documents (i.e. physician reports, hospital reports etc.) you feel may be necessary to establish your eligibility for a Disability Pension.*

I hereby certify that the foregoing statements, including any accompanying statements, are true, correct and complete to the best of my knowledge and hereby further authorize my attending physician, practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization that has facts concerning my medical care or physical condition, to disclose, whenever requested to do so by the Welfare and Pension Administration Service, Inc. any and all such information. A photo static copy of this authorization shall be considered as effective and valid as the original.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_ 20 \_\_\_\_\_

**PLEASE HAVE YOUR DOCTOR COMPLETE THE BACK SIDE OF THIS FORM.**

# TOTAL AND PERMANENT DISABILITY PENSION QUESTIONNAIRE

## ATTENDING PHYSICIAN'S STATEMENT

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_

Date First Treated \_\_\_\_\_ Date Last Treated \_\_\_\_\_

1. Diagnosis (Please provide ICDA codes if available) \_\_\_\_\_

\_\_\_\_\_

2. Frequency of care? Weekly  Monthly  Annual  Other \_\_\_\_\_

3. Symptoms are? Progressive  Stationary  Improving

4. Based on medical evidence, do you believe this Patient is totally and permanently disabled and prevented from performing duties of **his/her** occupation? Yes  No

Comments: \_\_\_\_\_

\_\_\_\_\_

5. Based on medical evidence, do you believe this Patient is totally and permanently disabled and prevented from performing the duties of **any** occupation for which he may be qualified by reason of training or experience?

Yes  No

Comments: \_\_\_\_\_

\_\_\_\_\_

6. Date disability commenced? \_\_\_\_\_

7. This disability does  or does not  result from a self-inflicted injury, habitual use of narcotics or habitual use of alcoholic beverages. If it does, please explain: \_\_\_\_\_

8. REMARKS: \_\_\_\_\_

\_\_\_\_\_

Date Physician's Name (Print or Type) Physician's Signature Degree Telephone No.

Street Address City or Town State or Province Zip Code

\_\_\_\_\_ or \_\_\_\_\_  
S.S.N. T.I.N.

**THIS FORM IS NOT VALID WITHOUT THE PHYSICIAN'S WRITTEN SIGNATURE. A STAMPED SIGNATURE IS NOT ACCEPTABLE.**