

Central Laborers' Welfare Fund

PO BOX 1267, JACKSONVILLE, IL 62651-1267

Phone – 800-252-6571

Fax – 217-243-8619

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.

NOTICE TO PARTICIPANTS IN THE CENTRAL LABORERS' PENSION FUND

If you are a **participant** in the **Central Laborers' Pension Fund**, you may be entitled to receive Pension Credit and/or Vesting Service for periods you are unable to work in Covered Employment because of a disability. To permit the Welfare Fund to share medical claims information with the Pension Fund regarding your disability, you must also sign an **Authorization for the Release Medical Records – Loss of Time & Non-Work Disability Credit Benefit**. The form is at www.central-laborers.com/forms/html or by calling 1-800-252-6571.

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 _____

Signature M.D. Date