Puget Sound Electrical Workers Pension Trust

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Administered by
Welfare & Pension Administration Service, Inc.

TOTAL AND PERMANENT DISABILITY PENSION QUESTIONNAIRE

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!**

EMPLOYEE'S STATEMENT

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

2. Mailing Address____
   Number *Street* *City* *Zip*

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 feel this illness is clearly life threatening and is reasonably expected to be of a terminal nature resulting in death within 6 months? **Yes** ☐ **No** ☐

5. 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::______________________________

6. 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:______________________________

7. Date disability commenced?______________________________

8. 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:____________________

9. 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.