Plumbers & Pipefitters Local 172 Pension Plan

6525 Centurion ● Drive Lansing ● MI ● 48917
(517)321-7502 or (833)767-0172

Application for Total & Permanent Disability Benefit

NAME: _____

SOC. SEC. NO.: _____ DATE OF BIRTH: _____

ADDRESS: _____ TELEPHONE: _____

_____

SPOUSE'S INFORMATION:

NAME: _____

SOC. SEC. NO.: _____ DATE OF BIRTH: _____

(COMPLETED CERTIFICATION OF MARITAL STATUS FORM MUST BE RETURNED WITH APPLICATION)

DATE LAST WORKED **OR** DATE YOU LAST PLAN TO WORK: _____

PRIOR LOCAL: _____ YEAR STARTED IN INDUSTRY: _____

LAST EMPLOYER: _____

INFORMATION CONCERNING DISABLED PARTICIPANT

NAME OF PHYSICIAN: _____ DATE OF TREATMENT: _____

ADDRESS: _____

Have you applied for Social Security Disability Benefits? ☐ YES ☐ NO
(Attach copy of Award Certificate if available)

I hereby apply for a Disability Benefit and hereby authorize by my signature below, any Physician or medical institution that has attended or examined me to disclose to the Board of Trustees of the Pension Fund any information or knowledge relating to my Disability. Further, I understand that I may be required to submit to medical examinations as directed by the Board of Trustees of the Pension Fund.

I hereby certify that the above information is, to the best of my knowledge, true and complete. Before final action is taken on the Application, I understand it will be necessary for me to provide the Board of Trustees with proof of eligibility and documentary proof of age for my Spouse (if any) and myself.

_____ _____

Applicant Signature Date

PHYSICIAN'S MEDICAL REPORT

(To be completed by Participant's Physician; please print clearly.)

Name: _____ SSN: _____

Address: _____

Summary of Findings: _____

Date of Examination: _____

Diagnosis: _____

_____

Pension Plan Definition of Total and Permanent Disability: *A Total and Permanent Disability shall mean a physical or mental condition, which on the basis of medical evidence, totally and permanently prevents a Participant from engaging in any regular occupation or employment which would be inconsistent with a finding of a total and permanent disability and which will be permanent and continuous during the remainder of his/her life. .*

Based on the above guidelines, please answer **all** of the following questions:

1. Does the Participant meet all of the qualifications for disability as defined above? If not, please explain?

   _____

2. If so, what date did the disability commence? _____

3. Does the disability appear to be permanent? _____

4. Can the Participant perform any work within his trade, and if so, with what restrictions?

   _____

_____ _____

Signature of Physician Date

_____ _____

Print Physician Name Telephone Number

_____

Address of Facility

6525 Centurion Drive • Lansing, Michigan 48917-9275
Toll-Free (833) 767-0172 • Fax (517) 321-7508
www.ualocal172benefits.org

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION BY INDEPENDENT MEDICAL EVALUATION

By executing this authorization, I am consenting to the release of protected, or confidential, health information. I am voluntarily executing this authorization.

I, _____ (Date of Birth: _____), have consented to submit to an independent medical examination pursuant to the terms of the Plan in connection with my application for disability benefits from the Plumbers and Pipefitters Local 172 Pension Fund ("Pension Fund").

I authorize the Pension Fund, its Trustees, employees and/or service providers (i.e. business associates) to obtain, use and disclose my protected health information (except psychotherapy notes) for the purpose of processing and administering my claim for a Disability Benefit. Such information to be disclosed includes examination findings, conclusions, test results, opinions, and any other information relevant to evaluating my state of health or any other information requested by the Pension Fund, which the Pension Fund, in its sole discretion, determines is necessary to process my application for benefits.

I understand that this authorization will expire when I am no longer eligible for a Disability Benefit, or when any claims and/or appeals, including legal proceedings, for such benefit have been exhausted. I understand that I have the right to revoke this Authorization at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this Authorization, I must give notice of my decision in writing to the Fund Office via mail at 6525 Centurion Drive, Lansing, MI 48917-9275 or via fax at (517) 312-7508. I understand that health information disclosed pursuant to this Authorization may be re-disclosed by the persons authorized above and that the Pension Fund cannot prevent or protect such re-disclosures.

_____ _____

Applicant's Signature Date

CERTIFICATION OF MARITAL STATUS

Federal law requires the Board of Trustees of the Pension Fund to confirm whether a previous spouse is entitled to any portion of your pension benefits. As such, it is necessary that we request the following certification and supporting documentation. **Failure to complete this form fully, *including signing it in front of a notary public*, and providing ALL documentation requested, will result in a delay of the processing of your application**.

Applicant's Name: _____ SSN: _____

Current marital status:

- ☐ SINGLE, NEVER MARRIED
- ☐ SINGLE, PREVIOUSLY MARRIED*
- ☐ MARRIED, NO PREVIOUS MARRIAGES
- ☐ MARRIED, WITH PREVIOUS MARRIAGE(S)*
- ☐ LEGALLY SEPARATED*

*If you have had previous marriages, please list the names of your ex-spouses, the dates of marriage and date of divorce or separation (if any of your previous marriages ended due to the death of your spouse at the time, please list the date of death):

Ex-spouse's Name	**Date of Marriage**	**Date of Divorce/Death**

Please provide complete copies of ALL marriage certificates, divorce decrees, separation agreements, Qualified Domestic Relations Orders, death certificate(s), and any other accompanying documents related to the termination of your previous marriage(s). If you do not have these documents, you should contact the appropriate court through which the proceedings occurred in order to obtain certified copies.

I hereby certify, subject to the penalty of perjury, that the above information is, to the best of my belief and knowledge, true and complete. ANY PERSON WHO SUPPLIES A FALSE CERTIFICATION IN CLAIMING A BENEFIT FORFEITS ANY RIGHT HE OR SHE MAY HAVE TO THE BENEFIT AND, UPON DISCOVERY, BECOMES LIABLE FOR FULL REPAYMENT OF ANY MONEY RECEIVED AS A CONSEQUENCE.

_____ _____

Applicant's Signature Date

Subscribed and sworn before me,
This _____ day of _____,
Notary Public,_____
County
State of _____
My commission expires _____

Notice to Notary Publics. If you are serving as witness to the signature of the Participant identified above, you should realize that Federal law requires that, unless the above "Certification of Marital Status" is executed in the presence of an authorized Fund Representative, it must be executed in the presence of a Notary Public. Accordingly, you must not only witness the actual signature identified above but also examine the signer's credentials to satisfy yourself that they are in fact the same individual identified above.