DISABILITY FORM

MEMBER COMPLETES AND SIGNS THIS FORM

MEMBER'S NAME	SOCIAL SECURITY #
ADDRESS: _____ _____	PHONE# _____ _____ DATE OF BIRTH _____ _____ _____
NAME OF LAST EMPLOYER	DATE LAST WORKED

ADDRESS OF LAST EMPLOYER:

_____

_____

NATURE OF INJURY OR ILLNESS: _____

INFORMATION ABOUT CURRENT PHYSICIAN TREATING YOU FOR THIS CONDITION

PHYSICIAN'S NAME_____ PHONE# _____

PHYSICIAN'S ADDRESS: _____

_____

INITIAL DATE OF INJURY OR ILLNESS	INITIAL DATE OF TOTAL DISABILITY
DATE FIRST TREATED	BY WHOM?

1. HAVE YOU BEEN AWARDED SOCIAL SECURITY DISABILITY BENEFITS? YES____ NO____
2. HAS SOCIAL SECURITY DISCONTINUED YOUR BENEFITS? YES____ NO____
3. IF YES TO # 2, GIVE THE DATE YOUR BENEFITS WERE TERMINATED AND THE REASON WHY

   DATE: _____ REASON FOR TERMINATION:

I HEREBY CERTIFY THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE RELEASE, WHEN REQUESTED BY LABORERS' COMBINED FUNDS OR ITS REPRESENTATIVES, OF ANY FACTS OR RECORDS CONCERNING MY MEDICAL CONDITION AND/OR DISABILITY. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

MEMBER'S SIGNATURE	DATE

FOR OFFICE USE ONLY

PROCESSOR:	DATE	VAILDATOR:	DATE

RETURN THIS FORM WITH ATTENDING PHYSICIAN'S STATEMENT TO:

LABORER'S COMBINED FUNDS
12 EIGHTH STREET, SUITE 500
PITTSBURGH, PA 15222
EMAIL: BENEFITS@LCFOWPA.COM
FAX: 412-263-2813

Laborers' COMBINED FUNDS OF WESTERN PENNSYLVANIA
Serving the Laborers' District Council of Western Pennsylvania Pension Fund, Welfare Fund and other affiliated Funds
12 EIGHTH STREET • SUITE 500 • PITTSBURGH, PENNSYLVANIA 15222
PHONE: 412-263-0900 • WEBSITE: www.lcfowpa.com

Dear Physician:

In order for our office to determine eligibility for a disability pension through the Laborers' District Council of Western Pennsylvania Pension Fund, please be advised our office requires a **thorough explanation** as to the **cause** and **nature** of this patient's disability. If there is insufficient space on the form to explain the disability in detail, please **submit a copy** of the summary discharge, narrative report or other similar document.

Without a copy of one of the above suggested documents, there will be a **delay in our determination** until the proper documents are submitted. Your cooperation on this matter is appreciated. If you have any questions, please do not hesitate to contact our office at 412-263-2173 or toll free at 1-800-242-2538.

Sincerely,

LABORERS' DISTRICT COUNCIL OF
WESTERN PENNSYLVANIA PENSION FUND

Pension Department

OVER

ATTENDING PHYSICIAN'S STATEMENT

DISABILITY FORM

MEMBER'S NAME	SOCIAL SECURITY #
ADDRESS	

PHYSICIAN COMPLETES AND SIGNS THIS FORM

DIAGNOSIS AND CURRENT CONDITION

DATE OF ACCIDENT / ILLNESS OR INITIAL SYMPTOMS	DATE FIRST CONSULTED	DATE OF MOST RECENT CONSULTATION
IS PATIENT TOTALLY DISABLED? YES ____ NO ____	INITIAL DATE OF DISABILITY	

HAS PATIENT BEEN CONTINIOUSLY AND TOTALLY DISABLED FROM THE CONDITION DESCRIBED ABOVE?
YES ___ NO___ IF NO, PROVIDE DATE TOTAL DISABILITY TERMINATED _____.

HOW LONG DO YOU ANTICIPATE THE PATIENT WILL BE TOTALLY DISABLED DUE TO THIS CONDITION?

ADDITIONAL COMMENTS
ON PATIENT'S CONDITION

_____(_____)_____-_____

Date Physician's Name (Print) Signature Degree Phone #

_____

Street Address City State Zip code

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