FLINT PLUMBING' & PIPEFITTING INDUSTRY PENSION FUND
APPLICATION FOR TOTAL AND PERMANENT DISABILITY BENEFITS

I hereby apply for **Total and Permanent Disability Benefits.** I understand that eligibility for these benefits is conditioned upon my being an Active Participant at the time I became disabled, my Years of Service since my Effective Date of Participation, and on my physical condition as determined by the Trustees.

I hereby authorize the Board of Trustees or the Administrative Manager of the Fund to obtain from my Physician whatever information deemed necessary to investigate or substantiate my claim for disability hereunder, and I hereby authorize my Physician (whose name and address appear below) to release such information to the Board of Trustees or the Administrative Manager upon written request when accompanied by a photocopy of this application form.

MY PHYSICIAN IS (Include the First, Middle and Last Name, as applicable):

_____

(First Name) (Middle Initial) (Last Name) (Degree)

_____

Type the Street Number, Directional Code, Street Name, Way Code, Unit Number, City, State and Zip Code, as applicable.

I hereby submit with this Application, a Physician's Medical Report, completed by my Physician, attesting to my disabled condition, and submit my Birth Certificate and Marriage Certificate (if applicable).

I UNDERSTAND THAT, IF I HAVE FILED FOR AND RECEIVED A DISABILITY AWARD FROM THE SOCIAL SECURITY ADMINISTRATION, I SHOULD ATTACH A COPY OF IT TO THIS APPLICATION.

PERSONAL INFORMATION (Please type or print):

Name of Applicant: _____

Include the First, Middle and Last Name, as applicable.

Social Security Number: _____ Date of Birth: _____

Home Address: _____

Type the Street Number, Directional Code, Street Name, Way Code, Unit Number, City, State and Zip Code, as applicable.

Home Telephone Number: _____ Present Local Union Number: _____

Last day of work before this disability occurred: _____

Name of Last Employer: _____Employer's Phone No. _____

MAILING INSTRUCTIONS (Complete only if different than the "Home Address" shown on the other side.):

Mail Benefit Check to: _____
Include the First, Middle and Last Name, as applicable.

_____
Type the Street Number, Directional Code, Street Name, Way Code, Unit Number, City, State and Zip Code, as applicable.

I hereby certify that the above information is, to the best of my belief and knowledge, true and complete. Before final action is taken on this application, I understand it will be necessary for me to provide the Trustees of the Pension Fund with a Physician's Medical Report, documentary proof of my Date of Birth, a copy of my Disability Award from the Social Security Administration, if any, and a copy of the Notice of Commencement of Compensation Payments from Workers' Disability Compensation, if applicable:

Date: _____ **Signature of Applicant:** _____

PHYSICIAN'S MEDICAL REPORT
(To be completed by Applicant's Physician)

TO: THE BOARD OF TRUSTEES OF THE
FLINT PLUMBING & PIPEFITTING INDUSTRY PENSION FUND

RE: Name:_____ Social Security Number:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Diagnosis: _____

Concurrent Conditions: _____

When did these symptoms first appear or accident/injury happen? Date: _____

Is the disability due to accident/injury or sickness arising out of the patient's employment? ☐ Yes ☐ No

When did the patient first consult you for this condition? Date: _____

How long have you know this patient? Since _____

When did you last examine this patient for this condition? Date: _____

Based on your examination of and conversation with the patient,

Was the disability contracted, suffered or incurred while he/she was engaged in or the result of his/her having engaged in a criminal enterprise? ☐ Yes ☐ No

Was the disability self-inflicted? ☐ Yes ☐ No

Is this patient totally unable to engage in his/her regular occupation or employment for remuneration or profit as the result of this disability? ☐ Yes ☐ No

As of what date did this occur? Date: _____

Do you consider this disability to be permanent? ☐ Yes ☐ No

If no, what is the probable future duration? _____

_____

Is this patient totally unable to engage in his/her regular occupation or employment at the plumbers' trade as the result of this disability? ☐ Yes ☐ No

As of what date did this occur? _____

Do you consider this disability to be permanent? ☐ Yes ☐ No

If no, what is the probable future duration? _____

_____

What employment can this patient engage in? _____

_____

What employment is this patient restricted from? _____

_____

_____

Physician's Signature: _____ Date: _____

Please type or print the following:

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Please return to:

FLINT PLUMBING & PIPEFITTING INDUSTRY PENSION FUND

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