Northern California Tile Industry Trust Funds

Health & Welfare • Vacation & Holiday • Defined Benefit Pension • Defined Contribution Pension

Physician's Statement – Disabled Dependent

Return completed form to:

Northern California Tile Industry
P.O. Box 1607
San Ramon, CA 94583

Trust Fund Phone #: (925) 208-9996
Toll Free #: (888) 208-0250
Fax #: (925) 462-0108

Part I – MEMBER/DEPENDENT INFORMATON:

1. Member's Name _____ Birth date: _____ SSN: _____

   Street _____

   City and State_____ Zip code_____ Member's Phone #_____

2. Disabled Dependent's Name _____ Birth date: _____SSN: _____

To Physicians, Hospitals and Other Institutions: I hereby authorize you by this form (or by photographic copy hereof) to give Stationary Engineers Local 39 Trust Fund any information you have regarding my dependent's medical history and physical condition for the dependent in question.

I certify the above answers are true and complete to the best of my knowledge and belief.

Dated_____ Mr._____ Mrs._____ Miss_____ _____

Member Signature – Please Do Not Print

Part II – ATTENDING PHYSICIAN'S STATEMENT

1. Is the dependent (patient) presently incapable of self-sustaining employment by reason of:

   Physical Handicap? Yes____ No____ Mental Handicap? Yes____ No____ Other?____ (explain)_____

2. What date did patient become disabled or incapable of self-sustaining employment: _____

3. How old was the patient when disability began? Disabled From Birth _____ or At Age _____

4. Diagnosis of condition causing incapacity. Give as much detail as possible. Please give date and report of surgery, X-Rays, electrocardiograms, or other special tests. Use separate sheet of paper if necessary._____

   _____

   _____

Functional Age Level:_____

5. Does the patient currently have a job? Yes____ No____

   a. Has the patient been able to do full or part-time work of any kind? Yes _____ No_____ If Yes, please give approximate date: _____

   b. Will the patient be capable of self-support in the future? Yes _____ No_____ If Yes, please give approximate date: _____

6. Remarks: _____

Date _____ Physician's Name (Print) _____Degree_____

Physician's Signature_____

Address_____

Physician's Phone Number_____