Ironworkers Intermountain Trust Fund
Physician's Statement – Disabled Dependent

Return completed form to:

Ironworkers Intermountain Health and Welfare Trust Fund
PO Box 30580
Salt Lake City UT 84130

Trust Fund Phone #: (801) 904-4897
Toll Free #: (888) 867-9510
Fax# (810) 386-7396

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 Participant, Please provide proof of your disabled dependents financial dependency such as a tax return showing you claim child as a dependent.

To Physicians, Hospitals and Other Institutions: I hereby authorize you by this form (or by photographic copy hereof) to give Ironworkers Intermountain 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_____