IRON WORKERS ST. LOUIS DISTRICT COUNCIL PENSION TRUST

DISABILITY CERTIFICATION FORM

You only need to complete this form if you are applying for a Form of Disability Pension under the terms of the Pension Plan. Please print or type your answers to all questions. If any questions on the application are unclear, please contact the Fund Office for assistance. After completing this certification, be sure to sign your name, date and return with your retirement application. ***The Fund Office recommends allowing 180 days to process your complete retirement request***.

The Trustees shall be the sole and final judges of a Participant's entitlement to an Occupational Disability Pension or a Disability Pension.

1. Name: _____
Last First Middle

2. Address: _____
Number & Street City & State Zip code

3. Social Security No.: _____ 4. Telephone No.: _____

5. Date of Birth: _____
Month Day Year

6. a. Nature of your disability: _____

b. Date you became disabled: _____

c. Physician's name, address, and telephone number: _____

_____

d. Date of your most recent examination: _____

e. Have you worked at all, at any occupation since you became disabled? ❒ Yes ❒ No

If yes, describe your work, amount of earnings and dates of employment.

Employer	From	To	Earnings	Type of Work

7. To qualify for a Form of Disability Pension, the following information must be submitted *(the Trustees may also request additional information):*

❒ **Occupational Disability Pension** - Complete pages 1 and 2, have your Physician complete the attached Physician Certification (page 3) & submit with your supporting medical records.

❒ **Disability Pension** – Complete page 1 and submit with your Social Security Disability Pension Award letter.

The foregoing statements are true to the best of my knowledge and belief. I understand that a false statement used to obtain pension benefits under the Plan may disqualify me for those pension benefits and that the Board of Trustees shall have the right to recover any payments made to me because of a false statement. I understand that if a benefit is granted to me, I agree to be bound by all the Rules and Regulations of the Plan.

_____ _____
Participant's Signature Date

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name: _____
Last First Middle

Social Security No: _____

I, the undersigned, hereby authorize the use or disclosure of my health information in connection with my application for the disability pension from the Iron Workers St. Louis District Council Pension Trust as described in this authorization.

1. I authorize the doctors, hospitals and medical providers listed below and their agents to release the personal health information described below.

2. I authorize the Iron Workers St. Louis District Council Pension Trust or its Third Party Administrator, BeneSys Inc., and its agents authorized to receive and use the information.

3. Specific and meaningful description of the information:
Information related to my eligibility for disability pension benefits based on

(briefly describe disability) _____

_____

_____

The information includes claims, reports, and other documents related to claims for dates of service

beginning (date): _____ *and continuing through (date):* _____

Other: _____

List doctors, hospitals, and medical providers:

_____

_____

_____

_____ _____
Participant's Signature Date

PHYSICIAN CERTIFICATION OF OCCUPATIONAL DISABILITY FORM

This form is required if you are applying for Occupational Disability Pension.

Participant's Name: _____ Date of Birth: _____

The following information must be completed by a physician. Please note, you may be required to submit to periodic examinations as directed by the Trustees.

1. Date first treated: _____

2. Nature of Disability ***(Please attach medical records):***

_____

_____

3. A Participant will be considered occupationally disabled under the terms of the Pension Plan only if The Board of Trustees, in their sole and absolute judgment, finds that the Participant by reason of any medically determined physical or mental impairment which has lasted or can be expected to last for a continuous period of not less than twelve months, is unable to perform a substantial portion of the regular job activities of an Iron Worker.

   In your opinion is the individual considered occupationally disabled?: ❒ Yes ❒ No

   Date considered occupationally disabled: _____

_____ _____
Physician's Name (Printed) Phone Number

_____
Street Address

_____
City, State, Zip Code

_____ _____
Physician's Signature Date