

I.B.E.W. LOCAL 332 PENSION TRUST FUND

ADMINISTRATIVE OFFICES

1120 S. BASCOM AVENUE, SAN JOSE, CA 95128-3590

(408) 288-4400

PART A DISABILITY APPLICATION

INSTRUCTIONS

1. Please read each question carefully
2. Print all information
3. Be sure to Sign and Date the Application
4. Be sure to have your Doctor complete the Physician's Statement
5. Submit a Proof of Age (refer to Proof of Age Instructions Attached)
6. Mail the completed Application and Physician's Statement to:
PO Box 5057
San Jose, CA 95150-5057

PERSONAL DATA

1. Participant's Name _____
(Last) (First) (Middle)
2. Address _____
Street City State Zip Code
3. Participant's SSN _____
4. Date of Birth _____
5. Telephone No. _____
6. Date of Disability: Month _____ Year _____
7. Last date worked: Month _____ Year _____
8. Beneficiary's Name _____
9. Beneficiary's SSN _____
10. Date of Birth _____
11. Marital Status: Married Single Divorced Widowed
IF DIVORCED, PLEASE PROVIDE COPY IF DIVORCE DECREE WITH PROPERTY SETTLEMENT
12. Is any portion of your Pension Benefit payable to someone else under a Court Order: Yes No

TYPE OF APPLICATION

13. I wish to apply for: Normal Retirement * Early Retirement
 Part B Disability Part A Disability Retirement Estimate Only

**IT IS ABSOLUTELY ESSENTIAL THAT YOU BE AS ACCURATE AS POSSIBLE IN YOUR REPLIES.
INCORRECT OR INCOMPLETE INFORMATION MAY DELAY PAYMENT OF YOUR PENSION BENEFITS.**

I realize that all information on this application will be used for determining my Benefits, if any, and I hereby declare under perjury that the foregoing is correct to the best of my knowledge.

Date

Signature

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INSTRUCTIONS CONCERNING SUBMISSION OF PROOFS OF AGE

The acceptable proofs of your age are listed below in two groups. Submit a photostatic copy of one of the proofs listed in Group I. If you have it, or can possibly obtain it since this class of proof of age is the more convincing.

If you cannot submit a proof in the Group I classification, submit photostatic copies of two (2) of the proofs listed in Group II. You are cautioned, however, that naturalization papers, United States Passports and Immigration papers may not be photostated. If you are submitting any of these, you must send the original. It will be returned to you.

Additional proofs of age may be requested if the documents you submit do not constitute convincing proof of your age.

GROUP I

1. A birth certificate.
2. A baptismal certificate or a statement as to the date of birth shown by a church record, certified but the custodian of such record.
3. Notification of registration of birth in a public registry of vital statistics.
4. Certification of record of age by the U.S. Census Bureau.
5. Hospital birth record, certified by the custodian of such record.
6. Document showing approval of Social Security Pension.
7. A foreign church or government record.
8. A signed statement by the Physician or midwife who was in attendance at birth, as to the date of birth as shown on their records.
9. Naturalization record. (Photostat not permitted: submit original)
10. Immigration papers (Photostat not permitted: submit original)

GROUP II

11. Military record
12. Passport. (U.S. passports may not be photostated: submit original)
13. School records, certified by the custodian of such record.
14. Vaccination record, certified by the custodian of such record.
15. An insurance policy which shows the age or date of birth.
16. Other evidence such as signed statements from persons who have knowledge of the date of birth.

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IBEW LOCAL 332 PART A

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY.

(PRINT) Name of Patient		Age	Policy Number
Present Address	City	State	Zip Code
If Group Insurance, Give Name of Policyholder		Insured Name (if Patient is dependent)	

1. HISTORY

- (a) When did symptoms first appear or accident happen? Month _____ Day _____ Year _____
- (b) Date patient ceased work because of disability: Month _____ Day _____ Year _____
- (c) Has patient ever had same or similar condition? Yes No
- If yes, state when and describe:

2. PRESENT CONDITION

- (a) Subjective symptoms
- (b) Objective findings
- Include results of current X-rays, EKGs or any other special tests.
- (c) Is patient: Ambulatory? Bed Confined? House Confined? Hospital Confined?

3. DIAGNOSIS

4. TREATMENT

- (a) Date of first visit Month _____ Day _____ Year _____
- Date of last visit Month _____ Day _____ Year _____
- Frequency of visits Weekly Monthly Other _____
- (b) When did you last examine the patient? Month _____ Day _____ Year _____

5. PROGRESS

Recovered Improved Unimproved Retrogressed

6. EXTENT OF DISABILITY

FOR ANY OCCUPATION

FOR REGULAR OCCUPATION

- (a) Is patient now **Totally Disabled**?* Yes No Yes No
- (b) If no, when was the patient able to return to work? Month _____ Day _____ Year _____
- (c) If yes, when do you think patient will be able to resume work?
- Approximate date: Month _____ Day _____ Year _____ Indefinite Never
- (d) If yes, is patient a suitable candidate for a rehabilitation program? Yes No

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7. MENTAL CONDITION

Is the patient competent to endorse checks and direct the use of the proceeds thereof?

Yes

No

Complete appropriate section(s) if the disability is due to CARDIAC CONDITION.

8. CARDIAC

(a) Functional capacity (American Heart Association)

Class 1
(no limitation)

Class 2
(slight limitation)

Class 3
(marked
limitation)

Class 4
(complete
limitation)

(b) Blood Pressure

REMARKS (PLEASE ATTACH SUPPORTING DOCUMENTATION):

Date	Signature (Attending Physician)	Print Name (Attending Physician), Degree	Telephone
Street Address	City or Town	State or Province	Zip Code

*The **Board of Trustees of IBEW Local 332** has requested that you review the medical evidence submitted and give us your opinion whether the above member is **Totally Disabled**, defined as the inability of the participant to perform all the duties of his/her regular occupation and thereafter the inability to perform any substantial gainful employment.

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AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me and any other non-medical information of me to give to:

UNITED ADMINISTRATIVE SERVICES

or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by:

UNITED ADMINISTRATIVE SERVICES

to determine eligibility for Disability Retirement Benefits. Any information obtained will not be released by:

UNITED ADMINISTRATIVE SERVICES

to any person or organization EXCEPT to reinsuring companies, or other persons, or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic valid as the original copy of this Authorization shall be as valid as the original.

I AGREE this AUTHORIZATION shall be valid during the pendency of this claim.

Signed this _____ day of _____, 20____.

Signature