

**FUND: MICHIGAN ELECTRICAL EMPLOYEES' PENSION FUND**

**APPLICATION FOR: TOTAL AND PERMANENT DISABILITY BENEFITS**

I hereby apply for **Total and Permanent Disability Benefits** from the Michigan Electrical Employees' Pension Fund. 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** (Please type or print):

_____	_____	_____	_____
(First Name)	(Middle Initial)	(Last Name)	(Degree)
_____		_____	_____
(Street Address)	(City)	(State)	(Zip Code)

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, SINCE IT WILL BE ACCEPTABLE PROOF OF MY DISABILITY.**

**I FURTHER UNDERSTAND THAT IF I HAVE NOT RECEIVED A DISABILITY AWARD FROM THE SOCIAL SECURITY ADMINISTRATION, I SHOULD FILE THIS APPLICATION AS SOON AS MY PHYSICIAN HAS DETERMINED THAT I AM TOTALLY AND PERMANENTLY DISABLED AND SEND IN THE DISABILITY AWARD FROM THE SOCIAL SECURITY ADMINISTRATION WHEN I RECEIVE IT.**

**PERSONAL INFORMATION** (Please type or print):

Name of Applicant: \_\_\_\_\_  
(First Name) (Middle Initial) (Last Name)

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Home Telephone Number: \_\_\_\_\_ Present Local Union Number: \_\_\_\_\_

**(PLEASE COMPLETE OTHER SIDE OF THIS APPLICATION)**

Revised: 5/99

Have you ever received benefits from the Michigan Electrical Employees' Health Care Fund which are related to this disability?

Yes

No

Have you ever received Workers' Compensation Benefits which are related to this disability?

Yes

No

If yes, please submit proof from the time you started collecting Workers' Compensation Benefits through the ending time or through the present (if still collecting), and proof of the weekly rate of benefits. *(You can obtain this information from your insurance carrier who handles your Workers' Compensation.)*

Have you ever worked in the jurisdiction of another Local Union of the International Brotherhood of Electrical Workers?

Yes

No

If yes, please identify the Local Union(s) as follows:

Local Union No. \_\_\_\_\_ City \_\_\_\_\_ Year(s) \_\_\_\_\_

Local Union No. \_\_\_\_\_ City \_\_\_\_\_ Year(s) \_\_\_\_\_

Local Union No. \_\_\_\_\_ City \_\_\_\_\_ Year(s) \_\_\_\_\_

Local Union No. \_\_\_\_\_ City \_\_\_\_\_ Year(s) \_\_\_\_\_

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:	_____	_____	_____
	(First Name)	(Middle Initial)	(Last Name)
_____	_____	_____	_____
(Street)	(City)	(State)	(Zip Code)

**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:** \_\_\_\_\_

***(PLEASE COMPLETE OTHER SIDE OF THIS APPLICATION)***

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

**TO: THE BOARD OF TRUSTEES OF THE MICHIGAN ELECTRICAL EMPLOYEES' 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
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<b>Was the disability self-inflicted?</b>	<b>Yes</b>	<b>No</b>
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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
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As of what date did this occur? Date: \_\_\_\_\_

Do you consider this disability to be permanent?	Yes	No
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If no, what is the probable future duration? \_\_\_\_\_

***(PLEASE COMPLETE OTHER SIDE OF THIS APPLICATION)***

Revised: 5/99

Is this patient totally unable to engage in his/her regular occupation or employment at the carpentry 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: \_\_\_\_\_

Please type or print the following:

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_  
(Area Code)

**MICHIGAN ELECTRICAL EMPLOYEES' PENSION FUND  
ATTN: KAREN WRESINSKI  
6525 Centurion Drive  
Lansing, MI 48917-9275**