Northwest Ironworkers Trust Funds

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Administered by
WELFARE AND PENSION ADMINISTRATION SERVICE, INC.

TOTAL AND PERMANENT DISABILITY PENSION QUESTIONNAIRE

NOTE: Please fill out this questionnaire completely, as all data is pertinent in determining your eligibility for a Disability Pension award from this Fund. Thank you!

EMPLOYEE'S STATEMENT

1. Employee's Name (Print)_____ Social Sec. No._____
   First Middle Last
2. Employee's Address _____
   Number Street City Zip
3. Date you last worked_____ Date Disability began _____ Phone No._____
4. Please state in your own words the nature of your disability_____
   _____
5. Was your disability caused by disease or injury resulting from work?_____
6. Have you filed a Claim for Workmen's Compensation? **Yes** ☐ **No** ☐ If "Yes", State Claim No._____
7. Have you filed for Social Security Disability? **Yes** ☐ **No** ☐ Has your claim been approved?_____
   If so, date of approval_____ **Please attach current proof of your entitlement to Social Security Disability Award benefits, such as a copy of your last check or a statement from Social Security.**
8. Please list name and address of all hospitals to which you were confined and doctors seen in the past year :

NAME AND ADDRESS OF HOSPITALS	NAME AND ADDRESS OF DOCTORS

9. Are you engaged in any rehabilitation or retraining?_____If yes, where? _____
10. Have you worked at **any** occupation since disability commenced? **Yes** ☐ **No** ☐
    a. If yes, please list the name and address of employer and the position you held while employed:_____
    _____
11. Please give a brief description of your employment, training and experience in this trade as well as any other professions:_____
12. Please advise of the highest level of education completed and of any specialized courses of study: _____
    _____

NOTE: When returning this form, you may include copies of any documents (in other words; physician reports, hospital reports etc.) you feel may be necessary to establish your eligibility for a Disability Pension.

I hereby certify that the foregoing statements, including any accompanying statements, are true, correct and complete to the best of my knowledge and hereby further authorize my attending physician, practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization that has facts concerning my medical care or physical condition, to disclose, whenever requested to do so by the Welfare and Pension Administration Service, Inc. any and all such information. A photo static copy of this authorization shall be considered as effective and valid as the original.

Employee's Signature:_____ Date:_____ 20_____

PLEASE HAVE YOUR DOCTOR COMPLETE THE BACK SIDE OF THIS FORM.

TOTAL AND PERMANENT DISABILITY PENSION QUESTIONNAIRE

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: _____ Age: _____

Date First Treated: _____ Date Last Treated: _____

1. Diagnosis (Please provide ICDA codes if available): _____

2. Frequency of care? Weekly ☐ Monthly ☐ Annually ☐ Other: _____

3. Symptoms are? Progressive ☐ Stationary ☐ Improving ☐

4. Based on medical evidence, do you feel this is a terminal illness that is reasonable expected to result in death within 6 months? **Yes** ☐ **No** ☐

5. Based on medical evidence, do you believe this Patient is totally and permanently disabled and prevented from performing duties of **his/her** occupation? **Yes** ☐ **No** ☐

   Comments: _____

6. Based on medical evidence, do you believe this Patient is totally and permanently disabled and prevented from performing the duties of **any** occupation for which he may be qualified by reason of training or experience?
   Yes ☐ **No** ☐
   Comments: _____

7. Date disability commenced? _____ Has disability been continuous? **Yes** ☐ **No** ☐

8. Is it your opinion that the disability will likely continue for the participant's lifetime or for an indefinite duration?
   Yes ☐ **No** ☐

9. This disability does ☐ or does not ☐ result from the following: a Self-inflicted injury, habitual use of narcotics or habitual use of alcoholic beverages. If it does, please explain: _____

10. ADDITIONAL REMARKS: _____

_____

Date *Physician's Name (Print or Type)* *Physician's Signature* *Degree* *Telephone No.*

_____

Street Address *City or Town* *State or Province* *Zip Code*

_____ *or* _____

S.S.N. *T.I.N.*

THIS FORM IS NOT VALID WITHOUT THE PHYSICIAN'S *WRITTEN* SIGNATURE. A STAMPED SIGNATURE IS *NOT* ACCEPTABLE.