Carpenters Retirement Plan of Western Washington

PO Box 1929 Seattle, Washington 98111 (206) 441-6514

Disability Retirement Questionnaire

Section 1 – Carpenter's Statement of Disability

Instructions

- You (the carpenter) must complete **Section 1 (pages 1-2) – Carpenter's Statement of Disability** in its entirety, sign and date it and then forward it to your physician.
- Your physician (MD or DO only) must complete **Section 2 (pages 3-4) – Attending Physician's Statement of Disability** in its entirety and then sign and date it. You or your physician must return the completed form to the Trust Office as soon as possible.

1. Name (please print): ______________________________
2. Social Security number: ____________ Date of birth: ____________
3. Occupation (please be specific): ______________________________
4. When did you last work? Month ____________ Day ____ 20 ____
5. When did you become disabled? Month ____________ Day ____ 20 ____
6. Describe your disability: ______________________________

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7. Is your condition the result of an injury? ____ Yes ____ No. If yes, please answer questions (a) - (c):
   (a) Date of injury: Month ____________ Day ____ 20 ____
   (b) What were you doing when you were injured? ______________________________
   (c) Where were you (please be specific)? ______________________________
8. When did you first seek medical attention? Month ____________ Day ____ 20 ____
9. Where were you first treated?______________________________

   Please list the names and addresses of all physicians you have seen and hospitals you have been confined in for this disability: ______________________________

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10. Have you ever been engaged in any rehabilitation whether or not you have received compensation?
    ____ Yes ____ No. If yes, please specify type of rehabilitation and the period of time in the program:

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11. Is your disability the result of a work-related injury or illness? ____ Yes ____ No. If yes, are you receiving workers' compensation? ____ Yes ____ No

12. Have you applied for or been granted a Social Security Disability award? ____ Yes ____ No. If yes, please provide the Trust with a copy of your Social Security award letter.
13. Have you been granted Medicare benefits? ____ Yes ____ No
14. Have you been engaged in any gainful employment since you were disabled? ____ Yes ____ No. If yes, please answer questions (a) – (c):
    (a) Are you presently employed in a full- or part-time position? ____ Yes ____ No. If yes, please describe your employment arrangement, job classification, name of employer and length of employment.

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    (b) List other crafts, trades and professions you have been employed in and the duties that you performed in each. If necessary, attach a separate sheet:

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    (c) Are you presently attending school or being retrained for another job classification? ❑ Yes ❑ No. If yes, please complete the following.

    Name of school: ____

    Course of study or major: ____

    Date expected to complete schooling or training: ______________________________

Carpenter's Authorization to Release Confidential Information

I hereby certify that the foregoing statements (including any accompanying statements) are true, correct and complete to the best of my knowledge. I further request and authorize my attending physician to release to this plan all facts, records and other information pertaining to my diagnosis, care and treatment for this disability. I understand that these records may contain information regarding the diagnosis or treatment of HIV, other sexually transmitted diseases, drug or alcohol abuse, mental illness, or psychiatric treatment. No further disclosure of the requested information will be made in accordance with Federal Law 42 CRF, Part 2. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Carpenter's Signature: ______________________________ Date: ____________________

For Administrative Use Only

Auditor's Signature: ______________________________ Date: ____________________

Retirement Effective Date: ____

Section 2 – Attending Physician's Statement of Disability

Instructions

- The carpenter must complete **Section 1 (pages 1-2) – Carpenter's Statement of Disability** in its entirety, sign and date it and then forward it to his or her physician.
- You (the carpenter's physician) must complete **Section 2 (pages 3-4) – Attending Physician's Statement of Disability** in its entirety and then sign and date it. You or the carpenter must return the completed form to the Trust Office as soon as possible.

Present Condition

1. Name of patient (please print): ______________________________
2. Date symptoms or injury occurred: Month ____________ Day ________ 20 ________
3. Date of first treatment: Month ____________ Day ________ 20 ________
4. Date disability commenced: Month ____________ Day ________ 20 ________
5. Has patient had the same or a similar condition before? ____ Yes ____ No. If yes, please state when and describe: ______________________________
6. Is this condition a result of an injury or illness arising from the patient's employment? ____ Yes ____ No.
7. Subjective findings: ______________________________
8. Objective findings: ______________________________
9. Diagnosis: ______________________________
10. Pertinent diagnostic findings (x-rays, laboratory and others): ______________________________
11. Date of last visit: Month ____________ Day ________ 20 ________
12. Frequency of treatments: Weekly ____ Monthly ____ Other ______________

Extent of Disability

1. As of this date, is the patient totally disabled (meaning incapable of performing any and every duty pertinent to his or her occupation as a carpenter, and not engaged in any other occupation for wage or profit)? ____ Yes ____ No. If no, what *specific* job duties is patient capable or incapable of performing? ______________________________
2. When did or when should patient be able to return to work? ______________________________

   If unknown, when is patient's next appointment? ______________________________

3. Have you placed any physical restrictions on this patient? ____ Yes ____ No. If yes, please explain: ____________

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Physician's Statement of Disability

Total and permanent disability, for the purposes of the Carpenters Retirement Plan of Western Washington and the Carpenters Individual Account Pension Plan of Western Washington means the disability or bodily injury or disease which, on the basis of medical evidence, can be assumed to be permanent and continuous during the remainder of the patient's lifetime and renders the patient incapable of performing any and every duty pertinent to his or her occupation.

I hereby certify that I have examined this patient and conclude that the patient **IS** or **IS NOT** (please circle one) totally and permanently disabled as described in the paragraph above. Please feel free to provide any additional information which will assist the Board of Trustees in making an informed decision about your patient's disability.

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Physician Information

1. Physician's name (please print):____
2. Address: ____
3. Medical degree and specialty: ________________________ Telephone: (   ) ____________
4. Physician's Signature:____________________________ Date:______________________

Disability Retirement (4-16-2010)