

Carpenters Retirement Plan of Western Washington

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

Disability Retirement Questionnaire – Follow-Up

Instructions

You must complete this form in its entirety, sign and date it and return it 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. Describe your disability: _____

5. Please list the name, address and telephone number of the physician you are currently seeing for this disability:

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

7. Are you currently 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:

8. 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.
9. Have you been granted Medicare benefits? Yes No

(over, please)

10. 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.

(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:

(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: _____