

# Cement Masons and Plasterers Trust Funds

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Administered by

Welfare & Pension Administration Service, Inc.

**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!

## TOTAL AND PERMANENT DISABILITY PENSION QUESTIONNAIRE EMPLOYEE'S STATEMENT

- Employee's Name (Print) \_\_\_\_\_ Social Sec. No. \_\_\_\_\_  
*First Middle Last*
- Employee's Address \_\_\_\_\_  
*Number Street City Zip*
- Date you last worked \_\_\_\_\_ Date Disability began \_\_\_\_\_ Phone No. \_\_\_\_\_
- Please state in your own words the nature of your disability \_\_\_\_\_  
\_\_\_\_\_
- Was your disability caused by disease or injury resulting from work? \_\_\_\_\_
- Have you filed a Claim for Workmen's Compensation? Yes  No  If "Yes", State Claim No. \_\_\_\_\_
- 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.**
- 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

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

*Please Note: When returning this form, you may include copies of any documents (i.e. 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 fact 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.**