INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS'
LOCAL NO. 445 PENSION FUND

APPLICATION FOR: TOTAL AND PERMANENT DISABILITY BENEFITS

I hereby apply for **Total and Permanent Disability Benefits** from the International Brotherhood of Electrical Workers' Local No. 445 Pension Fund. I understand that eligibility for these benefits is conditioned upon my being an Active Participant at the time I became disabled.

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, my Spouse's Birth Certificate (if applicable), a Marriage Certificate (if applicable), complete Divorce Decrees (if applicable) and a copy of my Honorable Discharge Papers from the Military-DD214 (if applicable).

I UNDERSTAND THAT, IF I HAVE FILED FOR AND RECEIVED A DISABILITY AWARD FROM THE SOCIAL SECURITY ADMINISTRATION, I MUST 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 OR HAVE BEEN DENIED SAID AWARD, IT MAY BE NECESSARY THAT I BE EXAMINED BY A FUND PHYSICIAN, AT NO COST TO ME, BEFORE MY APPLICATION CAN BE SUBMITTED TO THE BOARD OF TRUSTEES FOR APPROVAL.

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***)

Please indicate your marital status, where applicable: Page Two

- ☐ Married, number of times_____
- ☐ Legally Separated
- ☐ Widowed
- ☐ Single
- ☐ Divorced, number of times_____. Please submit complete copies of all of your Judgments of Divorce.

If currently married, please complete the following:

_____

Spouse's Name First Middle Last

_____

Spouse's Social Security Number Date of Birth Married on

Have you ever worked in the jurisdiction of another Local Union of the International Brotherhood of Electrical Workers' Local No. 445 Pension Fund, AFL-CIO and the hours have not been reciprocated to this Fund, please indicate below.

Please identify the Local Union(s) as follows:

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, a copy of my Birth Certificate, Spouse's Birth Certificate, Marriage Certificate, all complete copies of my Judgments of Divorce and a copy of my Disability Award from the Social Security Administration, if any.

Date: _____ **Signature of Applicant:** _____

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