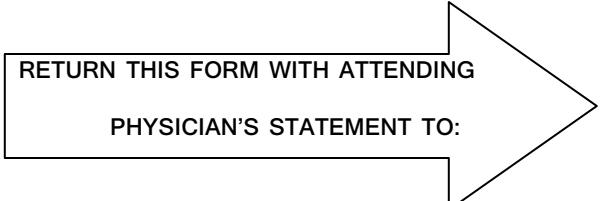


DISABILITY FORM

MEMBER COMPLETES AND SIGNS THIS FORM

MEMBER'S NAME		SOCIAL SECURITY #	
ADDRESS: _____ _____		PHONE# _____-_____-_____ DATE OF BIRTH _____-_____-_____	
NAME OF LAST EMPLOYER		DATE LAST WORKED	
ADDRESS OF LAST EMPLOYER: _____ _____			
NATURE OF INJURY OR ILLNESS: _____ INFORMATION ABOUT CURRENT PHYSICIAN TREATING YOU FOR THIS CONDITION PHYSICIAN'S NAME _____ PHONE# _____ PHYSICIAN'S ADDRESS: _____ _____			
INITIAL DATE OF INJURY OR ILLNESS		INITIAL DATE OF TOTAL DISABILITY	
DATE FIRST TREATED		BY WHOM?	
1. HAVE YOU BEEN AWARDED SOCIAL SECURITY DISABILITY BENEFITS? YES____ NO____ 2. HAS SOCIAL SECURITY DISCONTINUED YOUR BENEFITS? YES____ NO____ 3. IF YES TO # 2, GIVE THE DATE YOUR BENEFITS WERE TERMINATED AND THE REASON WHY DATE: _____ REASON FOR TERMINATION:			
I HEREBY CERTIFY THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE RELEASE, WHEN REQUESTED BY LABORERS' COMBINED FUNDS OR ITS REPRESENTATIVES, OF ANY FACTS OR RECORDS CONCERNING MY MEDICAL CONDITION AND/OR DISABILITY. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.			
MEMBER'S SIGNATURE		DATE	
FOR OFFICE USE ONLY			
PROCESSOR:	DATE	VALIDATOR:	DATE

RETURN THIS FORM WITH ATTENDING
PHYSICIAN'S STATEMENT TO:



LABORER'S COMBINED FUNDS
12 EIGHTH STREET, SUITE 500
PITTSBURGH, PA 15222
EMAIL: BENEFITS@LCFOWPA.COM
FAX: 412-263-2813



Laborers' COMBINED FUNDS OF WESTERN PENNSYLVANIA

*Serving the Laborers' District Council of Western Pennsylvania
Pension Fund, Welfare Fund and other affiliated Funds*

12 EIGHTH STREET • SUITE 500 • PITTSBURGH, PENNSYLVANIA 15222
PHONE: 412-263-0900 • WEBSITE: www.lcfowpa.com



Dear Physician:

In order for our office to determine eligibility for a disability pension through the Laborers' District Council of Western Pennsylvania Pension Fund, please be advised our office requires a **thorough explanation** as to the **cause** and **nature** of this patient's disability. If there is insufficient space on the form to explain the disability in detail, please **submit a copy** of the summary discharge, narrative report or other similar document.

Without a copy of one of the above suggested documents, there will be a **delay in our determination** until the proper documents are submitted. Your cooperation on this matter is appreciated. If you have any questions, please do not hesitate to contact our office at 412-263-2173 or toll free at 1-800-242-2538.

Sincerely,

LABORERS' DISTRICT COUNCIL OF
WESTERN PENNSYLVANIA PENSION FUND

Pension Department

OVER

ATTENDING PHYSICIAN'S STATEMENT

DISABILITY FORM

MEMBER'S NAME	SOCIAL SECURITY #
---------------	-------------------

ADDRESS

PHYSICIAN COMPLETES AND SIGNS THIS FORM

DIAGNOSIS AND CURRENT CONDITION

DATE OF ACCIDENT / ILLNESS OR INITIAL SYMPTOMS	DATE FIRST CONSULTED	DATE OF MOST RECENT CONSULTATION
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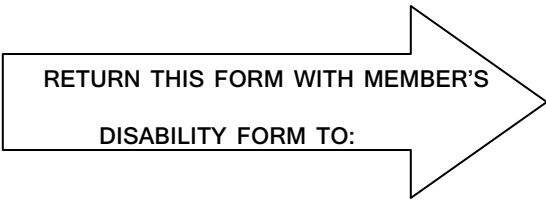
IS PATIENT TOTALLY DISABLED? YES ___ NO ___	INITIAL DATE OF DISABILITY
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HAS PATIENT BEEN CONTINUOUSLY AND TOTALLY DISABLED FROM THE CONDITION DESCRIBED ABOVE?
YES ___ NO ___ IF NO, PROVIDE DATE TOTAL DISABILITY TERMINATED _____.

HOW LONG DO YOU ANTICIPATE THE PATIENT WILL BE TOTALLY DISABLED DUE TO THIS CONDITION?

ADDITIONAL COMMENTS
ON PATIENT'S CONDITION

Date	Physician's Name (Print)	Signature	Degree	Phone #	
Street Address	City	State	Zip code		



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PITTSBURGH, PA 15222
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