Alaska Plumbing and Pipefitting Industry Pension Fund

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Phone (907) 561-5119 or (800) 325-6532 • Fax (907) 561-4802 • Website www.akpipetrades.com
Administered by
Labor Trust Services, 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

1. Employee's Name (Print)_____ Social Sec. No._____
   First Middle Last
2. Employee's Address_____
3. Date you last worked_____ Date Disability began_____ Phone No._____
4. Please state in your own words the nature of your disability_____
5. Was your disability caused by disease or injury resulting from work?_____
6. Have you filed a Claim for Workmen's Compensation? **Yes** ☐ **No** ☐ If "Yes", State Claim No._____
7. Have you filed for Social Security Disability?_____ Has your claim been approved?_____

   If so, date of approval_____ **Please attach a copy of your Social Security Disability Award Letter**
8. 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

9. Are you engaged in any rehabilitation?_____ If yes, where? _____
10. Have you worked at any occupation since disability commenced?_____
    a. If yes, please list the name and address of employer and the position you held while employed:_____
11. Please give a brief description of your employment, training and experience in this trade as well as any other professions: _____
12. 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; I hereby further authorize my attending physician, practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization that has facts concerning my medical care or physical condition, to disclose, whenever requested to do so by the Labor Trust Services, 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:_____

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 ☐ Annual ☐ Other:_____

3. Symptoms are? ☐ Progressive ☐ Stationary ☐ Improving

4. Based on medical evidence, do you feel this is a terminal illness that is reasonably 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, armed forces related condition or resulting from a criminal act. If it does, please explain:_____

10. 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. A PHOTOCOPY OF THE COMPLETED FORM IS *NOT* ACCEPTABLE.