FUND: MICHIGAN LABORERS' PENSION FUND

APPLICATION FOR: TOTAL AND PERMANENT DISABILITY BENEFITS

I hereby apply for **Total and Permanent Disability Benefits** from the Michigan Laborers' Pension Fund. I understand that eligibility for these benefits is conditioned upon my being an Active Participant at the time I became disabled, my Years of Service since my Effective Date of Participation, and on my physical condition as determined by the Trustees.

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, 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. *PLEASE SUBMIT MEDICAL EVIDENCE WITH THIS APPLICATON.*

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

- ☐ Married, number of times _____
- ☐ Legally Separated
- ☐ Widowed
- ☐ Single
- ☐ Divorced, number of times _____ Please submit complete copies of all 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 applied for Social Security Disability Benefits? ☐ **Yes** ☐ **No** ☐ **Pending**
(Attach a copy of "Notice of Award" letter if available.)

Have you ever received benefits from the Michigan Laborers' Health Care Fund which are related to this disability? ☐ Yes ☐ No

Have you ever received Workers' Compensation Benefits which are related to this disability?
☐ Yes ☐ No

If yes, please submit proof from the time you started collecting Workers' Compensation Benefits through the ending time or through the present (if still collecting), and proof of the weekly rate of benefits. *(You can obtain this information from the insurance carrier who handles your Workers' Compensation.* ***Without this information we cannot process your application.)***

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, documentary proof of my Date of Birth, a copy of my Disability Award from the Social Security Administration, if any, and a copy of the Notice of Commencement of Compensation Payments from Workers' Disability Compensation, if applicable:

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

6525 Centurion Drive, Lansing, MI 48917-9275
(517) 321-7502 • FAX (517) 321-7508
Toll Free 877-MI-LABOR (877-645-2267)
www.michiganlaborers.org

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

PHYSICIAN'S MEDICAL REPORT

(To be completed by applicant's physician)

TO: BOARD OF TRUSTEES OF THE MICHIGAN LABORERS' PENSION FUND

RE: Name_____ SSN_____

Address_____City_____State_____Zip Code_____

Diagnosis_____

Concurrent Conditions _____

When did these symptoms first appear or accident/injury happen? Date:_____

Was the disability due to accident/injury or sickness arising out of patient's employment?

Yes_____ No_____

When did patient first consult you for this condition? Date: _____

How long have you known this patient? Since_____

When did you last examine this patient for this condition? Date:_____

Based on your examination of and conversation with the patient:

Was the disability contracted, suffered or incurred while he was engaged in or the result of his having engaged in a criminal enterprise?

Yes_____ No_____

Was the disability intentionally self-inflicted?

Yes_____ No_____

If yes, how?_____

Is this patient totally unable to engage in any regular occupation or employment for remuneration or profit as the result of this disability?

Yes_____ No_____

As of what date did this occur? Date:_____

(***PLEASE COMPLETE OTHER SIDE OF THIS APPLICATION***) Revised: 11/04

Do you consider this disability to be permanent? Yes_____ No_____

If no, what is the probable future duration? _____

Is this patient totally unable to engage in his/her regular occupation or employment at the Laborers' Trade as the result of this disability?

Yes_____ No _____

_____

What employment can this patient engage in? _____

_____

What employment is this patient restricted from? _____

_____

Physician's Signature _____ Date_____

Please type or print the following:

Physician's Name _____Degree _____

Address _____

City_____ State_____Zip Code _____

Telephone No. (_____) _____
(Area Code)

Mail completed form to:

MICHIGAN LABORERS' PENSION FUND
6525 Centurion Drive
Lansing, MI 48917-9275
(517) 321-7502/FAX (517) 321-7508
(877) 645-2267

(***PLEASE COMPLETE OTHER SIDE OF THIS APPLICATION***) Revised: 11/04

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- You, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*signifies a required field).*

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**	***ADDRESS OF PERSON OR ORGANIZATION:**
Michigan Laborers' Pension Fund	6525 Centurion Drive, Lansing, MI 48917

***I want this information released because:**

We may charge a fee to release information for non-program purposes.

My pension benefit eligibility through the Michigan Laborers' Pension Fund is contingent on if I am currently receiving Social Security Disability Benefits and the effective date of the approved award.

***Please release the following information selected from the list below:**

You must specify the records you are requesting by checking at least one box. We will not honor a request for "any and all records" or "my entire file." Also, we will not disclose records unless you include the applicable date ranges where requested.

1. ☐ Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date _____ to date _____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☒ Other record(s) from my file **(you must specify the records you are requesting, e.g., doctor report, application, determination or questionnaire)**

   Record Extract: Confirmation that I am currently approved for Social Security Disability Benefits and the date of eligibility for such benefits.

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004)) that I have examined all the information on this form, and any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeks or obtain access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

***Address:** _____

Relationship (if not the subject of the record): _____ ***Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)