KENTUCKY LABORERS DISTRICT COUNCIL HEALTH & WELFARE FUND

1996 BY PASS SOUTH
LAWRENCEBURG, KENTUCKY 40342

Phone: (502) 839-8166

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STATEMENT OF TOTAL DISABILITY

FOR EXTENSION OF ACTIVE LIFE INSURANCE COVERAGE
AND/OR VERIFICATION OF ELIGIBILITY FOR RETIREE COVERAGE AS A DISABLED PARTICIPANT

PART 1

(TO BE COMPLETED IN FULL AND SIGNED BY MEMBER)

MEMBER'S NAME Last:	First:	M.I.:	SOC. SEC. #	PHONE # ( )
ADDRESS: Street/P.O.Box:		City:	State:	Zip:
Birth Date:	Last Day of Employment:		Date you became Totally & Permanently Disabled:	
INFORMATION REGARDING THE PHYSICIAN WHO IS TREATING YOU FOR THIS DISABILITY:	Name:_____ Street Address:_____ City:_____State:_____Zip:_____Phone #:_____ Date You Were First Treated by This Physician For This Injury: _____			

IS THIS DISABILITY DUE TO AN ACCIDENT? (Check [✔] one of the following boxes:	YES	NO

IF YOU ANSWERED "YES" TO THE QUESTION ABOVE, PLEASE GIVE ACCIDENT INFORMATION AS FOLLOWS:	
When did accident happen?	
Where did accident happen?	
How did accident happen?	
Was injury work-related?	

HAVE YOU WORKED AT ANY TYPE OF EMPLOYMENT SINCE YOU BECAME TOTALLY DISABLED? (Check [✔] one of the following boxes:	YES	NO

IF YOU ANSWERED "YES" TO THE QUESTION ABOVE, PLEASE GIVE EMPLOYMENT INFORMATION AS FOLLOWS:

Employers Names	Employers Addresses	Dates Employed (From / To)	Occupation

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I HEREBY AUTHORIZE ALL PHYSICIANS, HOSPITALS, OR OTHER PROVIDERS RENDERING TREATMENT TO FURNISH THE KENTUCKY LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND WITH FULL INFORMATION REGARDING TREATMENT RENDERED (INCLUDING COPIES OF MEDICAL RECORDS). i AUTHORIZED ANY UNION, TRUST FUND, ASSOCIATION, EMPLOYER, PROVIDER OF SERVICE OR INSURANCE CARRIER TO FURNISH THE KENTUCKY LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND WITH INFORMATION REGARDING BENEFITS TO WHICH I MAY BE ENTITLED OR HAVE RECEIVED. A PHOTOSTATIC COPY HEREOF SHALL BE AS VALID AS THE ORIGINAL.

_____ DATE

_____ SIGNATURE OF MEMBER

PART 2

(TO BE COMPLETED IN FULL AND SIGNED BY ATTENDING PHYSICIAN)

1. Patient's Name: _____ Soc. Sec. #: _____
   (Last) (First) (M.I.)

2. Diagnosis: _____

3. Please provide the following information regarding treatment of the patient:

   a. Date of first visit for this condition: _____

   b. Date of most recent visit for this condition: _____

   c. Frequency of visits for this condition: _____ Weekly _____ Monthly

      If not weekly or monthly, please explain further:

      _____

      _____

   d. Please give description of treatment being given for this disability:

      _____

      _____

4. Please answer the following questions regarding the extent of the patient's disability:

   a. Is patient totally disabled and unable to perform any work or engage in any occupation in the construction industry?

      _____Yes _____No

   b. If patient is totally disabled and unable to perform any work or engage in any occupation in the construction industry, please give the date that the patient <u>first</u> became totally disabled:

      _____
      Month / Day / Year

   c. If patient is <u>not</u> totally disabled and unable to perform any work or engage in any occupation in the construction industry, when do you anticipate that he will be able to return to work? (Please do not indicate "Unknown" or "Undetermined", but give an estimated date for return to work.)

      _____
      Month / Day / Year

Date _____
Signature of Attending Physician

_____
Name of Physician (Please Print)

_____
Address City State Zip

_____ _____
Phone Number Fax Number