FUND: MICHIGAN CARPENTERS' PENSION FUND

APPLICATION FOR: TOTAL AND PERMANENT DISABILITY BENEFITS

I hereby apply for **Total and Permanent Disability Benefits** from the Michigan Carpenters' 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, and submit my Birth Certificate and Marriage Certificate (if applicable).

I UNDERSTAND THAT, IF I HAVE FILED FOR AND RECEIVED A DISABILITY AWARD FROM THE SOCIAL SECURITY ADMINISTRATION, I SHOULD ATTACH A COPY OF IT TO THIS APPLICATION.

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***)

Have you ever received benefits from the Michigan Carpenters' Health and Welfare 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 your insurance carrier who handles your Workers' Compensation.)*

Have you ever worked in the jurisdiction of another Local Union of the Michigan Carpenters' and the hours have not bee 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)_____

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, 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: _____**

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