IBEW LOCAL 9 AND LINE CLEARANCE CONTRACTORS 401K RETIREMENT FUND APPLICATION FOR TOTAL AND PERMANENT DISABILITY BENEFITS

(TO BE COMPLETED BY APPLICANT)

I hereby apply for Total and Permanent Disability Benefits from the IBEW Local 9 and Line Clearance Contractors 401K Retirement Fund.

I hereby authorize the Board of Trustees or the Administrative Manager of the Fund to obtain from my physician whatever information may be 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 of the Fund 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 evidence of my date of birth.

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 SINCE IT WILL BE ACCEPTABLE PROOF OF MY DISABILITY.

PERSONAL INFORMATION •(Please type or print)

Name of Applicant_____
(First Name) (Middle Initial) (Last Name)

Social Security No._____ Date of Birth_____

Home Address _____
(Street)

(City) (State) (Zip Code)

Present Local Union No. _____ Telephone_____

(PLEASE COMPLETE OTHER SIDE OF THIS APPLICATION)

Have you ever worked as an Electrician (Line Clearance) in the jurisdiction of the IBEW Local 9 and Line Clearance Contractors 401K Retirement Fund?

Yes_____ No_____

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 IBEW Local 9 and Line Clearance Contractors 401K Retirement 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. Also, if I was previously married a copy of my formers wife's death certificate and/or complete copies of any Judgments or Divorce papers with all attachments.

Date _____ Signature of Applicant_____

PHYSICIAN'S MEDICAL REPORT

(To be completed by applicant's physician)

TO: THE BOARD OF TRUSTEES OF THE IBEW LOCAL 9 AND LINE CLEARANCE CONTRACTORS 401K RETIREMENT FUND

Regarding: 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?_____

How long have you known this patient? Since_____

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

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? _____

(PLEASE COMPLETE THE OTHER SIDE OF THIS APPLICATION)

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 regular occupation or employment at the 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. (___)_____

Mail completed form to:

IBEW Local 9 and Line Clearance Contractors 401K Retirement Fund
6525 Centurion Drive
Lansing, MI 48917-9275
(517) 321-7502/FAX (517) 321-7508
(877) 423-9155