DISABILITY CERTIFICATION

Laborer's Name _____ **Social Security No.** _____

Part I. Laborers Health and Welfare Plan Disability Hours Credit – PHYSICIAN must complete this section.

NOTE: A doctor's certification of disability must be filed with the Fund Office within one YEAR from the onset of the disability. otherwise, it will not be accepted for purpose of granting Health and Welfare disability hours.

This is to certify that the above-named was absent from Covered Employment as a laborer due to disability for the period:

from _____ to _____

Nature of disability is/was _____

Date you first examined patient for above condition _____

Physician's Name (print) _____ Telephone No. _____

Address _____

Physician's Signature _____ Date _____

Part II. Laborers Pension Plan Disability Hours Credit – LABORER must complete this section.

NOTE: The Laborer should complete this portion **ONLY** if he received Workers' Compensation or State Disability Insurance during the above disability period. **THIS IS NOT AN APPLICATION FOR A DISABILITY PENSION.**

The undersigned certifies:

1. That the disability is/was (check one): ☐ Occupational ☐ Non-occupational
2. That benefits have been paid by (check one): ☐ Workers' Compensation ☐ State Disability Insurance
3. If paid by Workers' Compensation, benefits were (check one): ☐ Temporary ☐ Permanent Disability Benefits

NOTE: Disability Hours credit cannot be granted if you have been deemed permanently disabled by Social Security Administration and you are receiving Social Security Disability Benefits. Please send a copy of your Social Security Award Notice to the Fund within 180 days of the issued date.

4. That the insurance carrier or name of agency making the payments described in Item No. 2 above is/was:

_____

5. That payments have been made (indicate dates) from _____ to _____
6. That the nature of the disability is/was _____
7. That the last day I worked as a Construction Laborer prior to my disability was _____

Part III. Laborer's Authorization for Release of Medical Information - LABORER must sign this section.

The undersigned patient authorizes any provider of health care, physician or other practitioner, hospital, insurer, self-insurer, consumer reporting agency, employer, union or other labor organization or group policyholder to furnish and disclose to the Laborers Health and Welfare Trust Fund for Northern California and the Laborers Pension Trust Fund for Northern California, or any person or entity representing the Funds, all records or other information in their control or within their knowledge concerning the Laborer's medical history, physical or mental condition, or any consultation, prognosis, diagnosis or treatment, for use solely in the processing of this claim for disability credit, including any procedure for the coordination of benefits or for reciprocity. The undersigned also authorizes the Funds or any person or entity representing the Funds, to acquire, posses, utilize and disclose information for the purpose of processing this claim for disability credit, including the disclosure to any provider of health care, insurer, self-insurer, hospital, health care service plan or employer, union, or other labor organization, or any person or entity representing any of the foregoing. This authorization will remain valid until the claim has been processed, including any procedures for review or investigation of the claim after having been processed. The undersigned has the right to receive a true copy of this signed authorization on request. This authorization is intended to be a valid authorization in accordance with California Civil Code Section 56.10 and is construed to give effect to that intention. A photocopy of this authorization is as valid as the original.

Laborer's Signature _____ Date Signed _____

Part IV. Laborer's Statement - LABORER must complete and sign this section.

The undersigned declares under penalty of perjury that the foregoing is true and correct.

Laborer's Signature _____ Date Signed _____

Address _____

Telephone No. _____ Local Union No. _____

PL 3004 (Rev. 01/2010)

Please return completed form to:

Laborers Pension Trust Fund for Northern California, 5672 Stoneridge Drive, Suite 100, Pleasanton, CA 94588