PROOF OF PERMANENT & TOTAL DISABILITY FOR EXTENDED DEATH BENEFIT

PART A. TO BE COMPLETED BY CLAIMANT'S BENEFICIARY

DECEASED'S NAME (Last, First, Middle Initial)	DECEASED'S SOCIAL SECURITY NO.:

ADDRESS (Street, City State & Zip Code)	TELEPHONE NO.:

WAS DECEASED RECEIVING A SOCIAL SECURITY DISABILITY PENSION? ☐ YES ☐ NO

DATE OF BIRTH	DATE LAST WORKED	DATE DISABILITY BEGAN

NAME OF EMPLOYER AT TIME OF DISABILITY BEGAN

ADDRESS (Street, City State & Zip Code)

DID DECEASED WORK FOR WAGES OR SALARY SINCE DISABILITY BEGAN? ☐ YES ☐ NO	IF YES, FOR WHOM DID DECEASED WORK?	PERIOD WORKED FROM TO

CAUSE AND NATURE OF DISABILITY

NAME OF PHYSICIAN WHO TREATED DECEASED

ADDRESS (Street, City State & Zip Code)

The undersigned hereby authorizes any provider of health care, physician, or other institution in which confinement or service took place, if any, to furnish and disclose to the Laborers Health and Welfare Trust Fund for Northern California, or any person or entity representing such Fund, all records or other information in their control or knowledge concerning his medical history, physical or mental condition, consultation diagnosis, or treatment, for use solely in the processing of within claim, including any procedure for the coordination of benefit. The undersigned also hereby authorizes such Fund to acquire, possess, utilize and disclose such information for such purpose, including the disclosure thereof to any provider of health care, insurer, self-insurer, hospital health care service plan or other group health plan, any employer of the person making the within claim or union representing such person, or any persons or entity representing any of the foregoing. This authorization shall remain valid until the claim has been fully processed, including any procedures for review or investigation of the claim after payment. The undersigned understands that he has the right to receive a true copy of this signed authorization upon demand. This authorization is intended to be valid authorization pursuant to California Civil Code Section 56.10 and shall be construed to give effect to this intention. A photocopy of this authorization shall be as valid as the original.

I hereby certify on behalf of myself that the foregoing statement, including any accompanying statements, are true correct and complete to the best of my knowledge.

DATE	BENEFICIARY'S SIGNATURE

SOCIAL SECURITY NO.	ADDRESS

DATE OF BIRTH	RELATIONSHIP TO DECEASED

ATTENDING PHYSICIAN TO COMPLETE REVERSE SIDE

PROOF OF PERMANENT & TOTAL DISABILITY FOR EXTENDED DEATH BENEFIT

PART B. TO BE COMPLETED BY ATTENDING PHYSICIAN

PATIENT'S NAME (Last, First, Middle Initial)	AGE

WAS PATIENT TOTALLY DISABLED AND PREVENTED FROM PERFORMING ANY WORK?

☐ YES

☐ NO (IF NO, DO NOT COMPLETE BALANCE OF FORM. PLEASE SIGN AND DATE FORM BELOW)

DIAGNOSIS

DATE FIRST TREATED	DATE LAST TREATED	DATE TOTAL DISABILITY BEGAN

FREQUENCY OF TREATMENTS ☐ YEARLY ☐ MONTHLY ☐ WEEKLY

WAS TOTAL DISABILITY CONTINUOUS?

☐ YES

☐ NO (IF NO, PROVIDE NON-DISABILITY PERIOD) FROM TO

WAS PATIENT ABLE TO WORK?	IF YES, WHEN?	SYMPTOMS WERE
☐ YES ☐ NO		☐ PROGRESSIVE ☐ STATIONARY ☐ IMPROVING

PATIENT WAS CONFINED TO:

☐ BED

☐ HOSPITAL

☐ HOME

☐ NOT CONFINED

I hereby authorize Laborers Health and Welfare Trust Fund for Northern California and its representatives to examine all medical records pertaining to the above-named deceased.

NAME & TITLE OF PHYSICIAN	TELEPHONE NO.:

ADDRESS (Street, City State & Zip Code)

DATE	SIGNATURE