

FUND: MICHIGAN ELECTRICAL EMPLOYEES' PENSION FUND

APPLICATION FOR: TOTAL AND PERMANENT DISABILITY BENEFITS

I hereby apply for **Total and Permanent Disability Benefits** from the Michigan Electrical Employees' 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, Middle and Last Names)

(Degree)

(Complete Physical Address)

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, SINCE IT WILL BE ACCEPTABLE PROOF OF MY DISABILITY.

I FURTHER UNDERSTAND THAT IF I HAVE NOT RECEIVED A DISABILITY AWARD FROM THE SOCIAL SECURITY ADMINISTRATION, I SHOULD FILE THIS APPLICATION AS SOON AS MY PHYSICIAN HAS DETERMINED THAT I AM TOTALLY AND PERMANENTLY DISABLED AND SEND IN THE DISABILITY AWARD FROM THE SOCIAL SECURITY ADMINISTRATION WHEN I RECEIVE IT.

PERSONAL INFORMATION (Please type or print):

Name of Applicant: _____
(Full Legal Name - First, Middle and Last Names, as applicable)

Social Security Number: _____ Date of Birth: _____

Home Address: _____
(Complete Physical Address)

Home Telephone Number: _____ Present Local Union Number: _____

Please indicate your marital status, where applicable

_____ Single

_____ Married, number of times _____

_____ Divorced, number of times _____ or widowed _____

If currently married, please indicate the following:

Spouse's Full Legal Name (First, Middle and Last Names, as applicable)

Spouse's Social Security Number

Date of Birth

Date Married

Have you ever received benefits from the Michigan Electrical Employees' Health Care Fund which are related to this disability? Yes No

Have you ever received Workers' Compensation Benefits which are related to this disability? Yes No

Have you ever worked in the jurisdiction of another Local Union of the I.B.E.W.? Yes No

If yes, 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. _____

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: _____

MICHIGAN ELECTRICAL EMPLOYEES' PENSION FUND
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(PLEASE COMPLETE OTHER SIDE OF THIS APPLICATION)