ENGINEERS JOINT BENEFIT FUNDS

LOCAL UNIONS 17, 106, 463, 545, 832

OF THE

International Union of Operating Engineers, A.F.L.-C.I.O.

101 INTREPID LANE
P.O. BOX 100 COLVIN STATION
SYRACUSE, NEW YORK 13205-0100

DANIEL P. HARRIGAN
ADMINISTRATOR

18

PHONE: (315) 492-1796
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APPLICATION FOR DISABILITY HOURS
TO BE COMPLETED BY MEMBER

Please Print All Answers

1. Your Name..Social Security Number..............................

2. Your Address..Telephone No. ....

   City..State..............................

3. Last Employed by (Contractor's Name)..

   Address and Job Location..

4. Last Day Worked..

5. Previous Employer..

   ....

   ....

6. Age.. Union Local No. ....

7. Date.. Member's Signature..............................
   (Do Not Print)

(over)

CERTIFICATE OF ATTENDING PHYSICIAN OR SURGEON

(Please fill in all dates carefully)

I certify I attended .... Age...................... Sex ....

I hereby certify that he/she was under my care totally disabled and prevented from performing all

duties of his/her occupation from...,20....... to...,20........

This patient should be able to return to work: ....,20........

In your opinion is disablility due to an injury arising out of patient's employment? ....

Diagnosis (legible please)...

....

....

Additional remarks: ....

....

....

Physician's Name (Please print)...Phone...

Address...

Workmen's Compensation Board Authorization Number...

Date... Physician's Signature...

(over)