TO: I.B.E.W. Local Union #716 Pension Trust
8441 Gulf Freeway, Suite 304
Houston TX 77017-5066

RE: Name of Application ____

Address ____

Social Security No. ______________________ Phone No.______________________

If you ARE presently receiving a Social Security Disability Award, check here p____

Date, sign and return this form as soon as possible, along with copy of evidence of entitlement to Social Security Award (copy of Award, copy of most recent Social Security check or other evidence).

Date ____________________________ Signature ______________________________

If you ARE NOT on a Social Security Disability pension, have your doctor complete the form below and return it as soon as possible.

I hereby authorize my Physician to release any of my medical records required by the I.B.E.W. Local Union #716 Pension Trust, in order to determine my qualifications for a disability pension under the Plan.

Date ____________________________ Signature ______________________________
(Pensioner)

This is to certify that the above named Pensioner is unable to engage in substantial gainful activity because of disability.

The following information is offered in support of this certification:

1. Nature of disability and date of onset: ________________________________

____

2. Diagnosis: ____

____

3. History: ____

____

____

4. Pertinent lab or x-ray findings: ______________________________________

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5. Date you last examined or treated patient for above condition: ___________________________

6. Was hospitalization necessary in connection with above condition?

Yes _________, No _________. If yes, enter dates of hospitalization below:

From: _____________________ to _________________________.

7. Was patient confined to home due to disability? Yes ________ No _______

If yes, indicate period of home confinement:

From: ____________________ to _________________________ .

8. Are you still treating patient for above condition?

Yes _______________ No _______________

9. Do you expect to treat patient for this disability again?

Yes _______________ No _______________ If yes, please advise expected date of next treatment: ______________________

10. In your opinion, is the patient totally and permanently unable as a result of bodily injury or disease, to engage in any substantial gainful activity, and can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months?

Yes ________ No _______________

Date ______________________ Signature ___________________________________
(Attending Physician)

____
(Print Physician's Name)

____
(Street Address)

____
(City/State/Zip Code)

____
(Phone Number)