Teamsters Pension Trust Fund of Philadelphia & Vicinity
Application for Disability Retirement Benefits
Joint Council No. 53 Retirement Plan Benefits

Date:__________________

Member Information
Please read all questions carefully and print your answers

(1) Applicant's Name:____
First Middle Initial Last

(2) Applicant's Social Security #:__________________________ *Attach copy of Social Security Card*

(3) Applicant's Date of Birth:_______________________ *Attach copy of Birth Certificate*

(4) Applicant's Address:____

___________________________________ Phone #:________________________

Cell Phone #:___________________________ Email:_________________________

(5) **Intended Retirement Date**: (Month/Day/Year)_________________________________

(6) Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated☐ (check one box only)

Note: If you are currently *Divorced* or *Widowed*, you must attach a full copy of your divorce decree with any property settlement agreement that might be attached or your spouse's death certificate.

Spouse Information

(7) Spouse's Name (Maiden):____
First Middle Initial Last (Maiden)

If spouse's maiden name is different than indicated on the Marriage Certificate, please attach appropriate documents to substantiate each name change.

(8) Spouse's Social Security#:____________________________ *Attach copy of Social Security Card*

(9) Spouse's Date of Birth: (Month/Day/Year)______________________ *Attach copy of Birth Certificate*

(10) Date of Marriage: (Month/Day/Year)_________________________ *Attach copy of Marriage Cert.*

Military Service
Attach a copy of discharge or separation papers if time served was while you were in Covered Employment.

(11) Have you ever served in the U.S. Military?___________________________________

Dates of Service: To:_____________________ From:_____________________

Record of Disability Benefits

(12) Have you ever received Weekly Disability Benefits?______________________________

(13) If so, when?(*list all dates*)____

(14) Have you ever received Workmen's Compensation Benefits?_________________________

(15) If so, when?(*list all dates*)____

(16) Have you applied for Social Security Disability Benefits?__________________________

(17) Have you been approved or denied Social Security Disability Benefits?_______________

(18) If approved, when?_____________________________ Attach copy of Social Security Disability Award

(19) List the name and address of each physician you have seen due to your disability.

If you need additional space, please use the back of this page.

Name and Addresses of any Physician you have seen regarding your Disability

Name of Physician	Address	Specialty	Periods of Treatment (From – To)

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I hereby apply for a Disability Joint Council No. 53 Retirement Pension from the Teamsters Pension Trust Fund of Philadelphia and Vicinity. I, being duly sworn, attest that I have read and understand the foregoing statements and my answers and information therein contained and that the same are true and correct to the best of my knowledge and belief.

____

Member's Signature ***(Signature must be notarized or witnessed by a Plan representative)*** Date

____

Fund Representative (witness) Date

Sworn before me this _______________ day of _________________, __________.

Day *Month* *Year*

____

Notary Public

Application for Disability Benefits

Attending Physician's Statement (to be completed by physician)

Please answer all the questions listed below. This information will be used to assist the Fund in determining whether the applicant is Totally and Permanently disabled, for the remainder of their lifetime. This statement is to be furnished without expense to the Fund.

Applicant's Name:____

Date you began treating this patient for his/her present illness or injury?__________________

When did the applicant's illness or injury begin?______________________________

When did the applicant stop working due to this illness or injury?____________________

Did the applicant have a previous history of this illness or injury?____________________

Please list below the claimant's symptoms, diagnosis and prognosis for the applicant's present condition:

____

____

____

In your professional opinion, do you believe this Participant is Totally and Permanently disabled, unable to perform any work for wage or profit for the remainder of their lifetime, including sedentary work. Please answer Yes or No. ______________________________

Is the applicate presently: *Please circle one*

ambulatory confined to bed confined to house hospitalized

Please indicate from what date:____

In your professional opinion, do you believe the applicant will be able to perform any type of employment in the future? Including, but not limited to, sedentary, part-time or full-time employment.

__________If yes, what date would you presume the applicant may return to work ?__________

If this disability involves a mental condition, is the applicant competent to endorse checks and direct the use of the proceeds thereof with a clear understanding of the nature of his/her acts? YES or NO

____ Office Stamp

Physician's Signature Physician's Printed Name

____

Address

____

Witness Date