Alaska Laborers Trust Funds

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Administered by
Labor Trust Services, Inc.

TOTAL AND PERMANENT DISABILITY QUESTIONNAIRE
FOR PENSION LEAVE OF ABSENCE

Employee's Statement

Please fill out this questionnaire completely as all data is pertinent to determining your eligibility for Pension Credit.

Name *(Last, First, Middle Initial)*			Social Security Number
Mailing Address *(Street, City, State, Zip)*			
Union Local No.	Birth Date *(MM/DD/YYYY)*[1]	Home Phone No. ( )	Cell Phone No. ( )
Email Address			

1. Date you were first disabled by the illness or injury: _____
2. Date you were first treated by Physician: _____
3. Physician's Name: _____
4. Date you last worked: _____
5. Was your disability caused by a work related disease or injury? ☐ Yes ☐ No
6. Have you filed a claim for Worker's Compensation? ☐ Yes ☐ No
   a. If "Yes", state the claim number: _____
7. If this disability is due to an injury, answer the following:
   a. When did the injury happen? _____
   b. Where did the injury happen? _____
   c. Describe the injury and explain how it happened: _____
8. Have you returned to work? ☐ Yes ☐ No
   a. If "Yes", on what date did you return to work?
   b. If "No", when do you expect to return to work?
9. Use this space to provide any other information you wish to consider for your claim.

I hereby certify that the foregoing statements, including any accompanying statements, are true, correct and complete to the best of my knowledge and hereby further authorize my attending physician, practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization that has facts concerning my medical care or physical condition to disclose, whenever requested to do so by Labor Trust Services, Inc. any and all such information. A photo copy of this authorization shall be considered as effective and valid as the original.

Employee's Signature _____ Date _____

HAVE PHYSICIAN COMPLETE PAGE 2 OF THIS FORM

TOTAL AND PERMANENT DISABILITY QUESTIONNAIRE FOR PENSION LEAVE OF ABSENCE

Attending Physician's Statement

1. Patients Name: _____
2. Patient's Age: _____
3. Accident Case ☐ Yes ☐ No
4. Nature of illness or injury (describe complications, if any): _____

   _____

   _____

   _____
5. Did illness or injury arise out of patient's employment? ☐ Yes ☐ No
   a. If "Yes", please explain: _____
6. Is disability due to pregnancy? ☐ Yes ☐ No
   a. If "Yes", delivery date: _____
7. Nature of surgical or obstetrical procedure, if any (describe fully): _____

   _____
   a. Approach: ☐ Abdominal ☐ Endoscopic ☐ Vaginal ☐ Other
8. Date surgery performed: _____
   a. If in hospital: ☐ Inpatient ☐ Outpatient
9. Give dates and nature of treatments:

Date and Place			**Nature of Service**
Home	*Hospital*	*Office*	*Examination, Treatment, Surgery, etc.*

10. The patient has been continuously disabled (unable to work) from _____ , through
    (MM/DD/YYYY)

    _____ .
    (MM/DD/YYYY)
    a. If still disabled, when should patient be able to return from work? _____
11. Remarks: _____

    _____

_____ _____ , M.D.

Date Signed

_____ _____

T.I.N. Address (Street)

_____ _____

S.S.N. Address (City, State and Zip)