Trust Fund Office
Laborers Health & Welfare Trust Fund For Southern California
4399 Santa Anita Avenue, Suite 200-El Monte, California 91734
Mailing Address: P.O. Box 8024 - El Monte, CA 91734
T 626-279-3000 - 1-800-887-5679 - F 626-279-3094

Application for Disability Freeze Benefits for Active Members

Employee: Complete Part I. Please answer all questions fully to help expedite the evaluation of your claim.

- Remember to sign and date the Fraud Statement.
- Ask your physician to complete Part II.

Part I and Part II should be returned at the same time to the Trust Fund Office within 30 days to the address listed below:

Mail both (Part I and Part II) Statements to:	Laborers Health & Welfare Trust Fund For Southern California P.O. Box 8024 El Monte, CA 91734

PART I – EMPLOYEE'S/MEMBER'S STATEMENT

First Name	M.I.	Last Name	Social Security Number
Date Of Birth (Mo/Day/Year)	Gender [ ] Male [ ] Female	Marital Status [ ] Single [ ] Married [ ] Divorced [ ] Widowed	
Mailing Address			Apt. Number
City	State	Zip Code	Telephone No.
Occupation	Local Union	Date Last Worked (Month / Day / Year)	Are You Entitled to Any Of The Following Benefits: [ ] Workers Compensation [ ] Social Security Disability
Date Accident Or Illness Began: (Month / Day / Year)			
Date First Treated By Physician For Disability: ______________________ (Provide Month / Day / Year)			
Were You Injured At Your Job? [ ] No [ ] Yes	(If Injured, How, When And Where Did Accident Happen?)		
Have you applied for Social Security Disability: [ ] Yes: Month___ Year____ [ ] No	Have You Filed A Disability Freeze Previously? [ ] Yes: Month____ Year______ [ ] No		

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PART I – EMPLOYEE'S/MEMBER'S STATEMENT (CONTINUED)

Employee's Telephone Number ________________

Name, Address And Telephone Number Of Each Physician Who Treated You For Your Disability

Misrepresentation And Fraud

In the event you or any **Member/Employee** receives benefits because of any misleading or fraudulent representations to the Plan, you will be liable to repay all amounts paid by the Fund. Fraud includes failure to disclose any information regarding other group health coverage under the Plan's coordination-of-benefits provisions or failure to disclose information regarding no-fault automobile coverage, Workers' Compensation or third-party liability under the Fund's Equitable Lien and Subrogation provisions. Furthermore, the Board of Trustees must ensure that all who benefit from the Plan do so appropriately and only as they are entitled. For example, if the Trustees determine that an Employee, his dependents, or health care provider has made any misrepresentation (whether or not intentional) in connection with claims for benefits or has committed any act or omission resulting in abuse or misuse of the Plan, the Board of Trustees reserves the right and authority to impose upon Employees and their Dependents restrictions with respect to their future rights to receive benefits from the Trust. The Trustees reserve the right to seek reimbursement and other damages, together with attorney's fees (to the extent provided by law) and other costs incurred in connection with recovering any benefits incorrectly paid, or not reimbursed, when reimbursement is required under the Plan. To be reimbursed for benefits improperly paid, the Trustees may also exercise a right of offset against future benefits payable on behalf of the Employee and his Dependents. In addition to the specific circumstances set forth elsewhere in this document in which the Trustees may suspend the payment of benefits to a participant or a beneficiary, the Trustees shall also have the general power to withhold and offset such benefits for claims incurred on behalf of the any participant or beneficiary who:

1. owes money to the Trust because of any obligations imposed upon them by this Plan booklet or the rules and regulations of the Trust, or
2. owes money to the Trust because the Trust overpaid a participant or beneficiary, or
3. in any other circumstances in which a participant or beneficiary legally owes money to the Trust.

The Trustees also reserve the right to refuse payment for services rendered or facilities or supplies furnished by particular health care providers. These powers may be used as the Trustees deem necessary.

THESE STATEMENTS IN PART 1 ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

____
(PRINT) NAME OF EMPLOYEE/MEMBER

______________________________ ______________________________
SIGNATURE OF EMPLOYEE/MEMBER DATE

PART II – PHYSICIAN'S STATEMENT

Mail both Part I and Part I Statements to Laborers Health & Welfare Trust Fund For Southern California
P.O. Box 8024, El Monte, CA 91734

Name of Patient				Social Security Number
Address				Date of Birth (Mo/Day/Year)
City	State	Zip Code		

HISTORY OF INJURY OR ILLNESS

When did symptom first appear or disability happen?	Month	Day	Year
Date patient was unable to work because of disability?	Month	Day	Year

Has patient ever had same or similar condition?
[ ] No.
[ ] Yes, Month____ Day___ Year___ (If yes, describe similar condition below.)

Description of similar condition.

Names and addresses of other treating physicians:

DIAGNOSIS

Diagnosis (including any complications): ____________________

ICD10 Code: ________

Subjective symptoms:

Objective findings (clinical notes and surgical reports are not necessary):

DATES OF TREATMENT

Date of first visit:
Month___ Day ___ Year

Date of last visit:
Month___ Day ___ Year

Frequency [ ] weekly [ ] monthly
[ ] Other (specify) _______________

NATURE OF TREATMENT (including any medications prescribed, if any)

PROGRESS

Patient has [ ] Recovered [ ] Improved [ ] Unchanged [ ] Retrogressed

Patient is [ ] Ambulatory [ ] House Confined [ ] Bed Confined [ ] Hospital Confined

PART II – PHYSICIAN'S STATEMENT (CONTINUED)

HOSPITALIZATION

Has patient been hospital confined? [ ] Yes [ ] No If "Yes", hospital name ______________________

Address ____ Confined from _________ through __________

PHYSICAL IMPAIRMENT (*as defined in Functional Dictionary of Occupational Titles)

[ ] Class 1 – No limitation of functional capacity of heavy work *No restrictions (0 -10%)
[ ] Class 2 – Medium manual activity *(10-30%)
[ ] Class 3 – Slight limitation of functional capacity, capable of light work * (35 – 55%)
[ ] Class 4 – Moderate limitation of functional capacity, capable of clerical/administrative (Sedentary*) activity (60 – 70%)
[ ] Class 5 – Severe limitation of functional capacity, incapable of minimal (Sedentary*) activity (75 – 100%)

[ ] Remarks:____

____

PROGNOSIS

What are the patient's current restrictions and limitations?

When was patient able to resume work? (If unknown, provide estimated date) Month___ Day___ Year ___

Do you expect a fundamental or marked change in the future including improvement and/or deterioration?	[ ] Yes [ ] No [ ] 1 Month [ ] 1-3 Months [ ] 3-6 Months [ ] Indefinitely [ ] Never

REHABILITATION

Is patient a suitable candidate for further rehabilitation services? [ ] Yes [ ] No
(For example, cardiopulmonary program, speech therapy if meets the Plan's rules.)

REMARKS

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF

(Print) Name of Treating Physician completing this form		Degree/Specialty	Tax ID Number	
Address		City	State	Zip Code
Telephone Number	Fax Number			
Signature of Treating Physician				