APPLICATION FOR DISABILITY RETIREMENT BENEFITS

Complete all applicable sections and return with required attachments to:

William C. Earhart Co., Inc.
PO Box 4148
Portland, Oregon 97208
(877) 396-2960 OR (503) 460-5260

SECTION 1 - PARTICIPANT INFORMATION

Name | Social Security Number | Date of Birth

Street Address | City | State | Zip code

Telephone Number | Email Address

Last Contributing Employer | Date employment ended (or will end) | Local Union No.

SECTION 2 – EMPLOYER INFORMATION (This section MUST be completed)

Current employer (any industry or occupation) | Job Title

Employer Address | Date employment ended (or will end)

Name of Supervisor or HR Representative | Telephone # | E-mail Address

SEX: ☐ Male ☐ Female **MARITALSTATUS (you must mark one):**

☐ **I AM MARRIED** ☐ **I HAVE NEVER BEEN MARRIED** ☐ **I AM DIVORCED** ☐ **I AM WIDOWED**

Name of Spouse/Beneficiary | Social Security Number | Date of Birth

Street Address | City | State | Zip code

Telephone Number | Email Address

I hereby apply to **WESTERN STATES OFFICE AND PROFESSIONAL EMPLOYEES PENSION FUND** for a:

☐ Disability Retirement

RETIREMENT EFFECTIVE DATE: _____

DIVORCE QUESTIONNAIRE

Name: _____ ☐ Not Applicable

Do you have a QDRO ☐ yes ☐ no ☐ I don't know

IF YES: Dates of your QDRO: _____

Previous Marriage

Date Married: _____

Date Divorced: _____

Names Pension Plan? ☐ yes ☐ no

All Pages Included? ☐ yes ☐ no ☐ I don't know

Signed by Judge? ☐ yes ☐ no ☐ I don't know

Court certified copy? ☐ yes ☐ no ☐ I don't know

Ex- Spouse Info

Current Name: _____

Last Known Address: _____

_____

Phone: _____

SSN: _____

DOB: _____

RECIPROCITY: This pension fund has reciprocity agreements with some other pension plans. Have you worked for another employer in the same industry? ☐ YES ☐ NO If yes, please list below any other employers in which you worked in the industry.

Union No.	Name of Employer & Address	Period of Time

SIGNATURE REQUIRED

By my signature below, I hereby swear that the information provided on this application is true and complete to the best of my knowledge and have provided all documentation necessary for processing my application. I understand that benefits may be delayed if I do not provide all required signatures and/or documentation, including resolution of Qualified Domestic Relations Order "QDRO" issues.

I also understand that I am not considered "retired" if I do not terminate my employment with a contributing employer PRIOR to commencing my pension benefits, or if I have a "termination and rehire" agreement, arrangement or understanding with my employer (formal or informal); I would not be eligible for retirement benefits.

SIGNATURE _____ **DATE**_____

IF YOU ARE APPLYING FOR A DISABILITY PENSION - THIS SECTION MUST BE COMPLETED AND SIGNED BY APPLICANT

Nature of your disability _____

_____

Date you first became disabled _____

Occupation _____

Briefly describe what is physically required to perform your job _____

_____

_____

If you have worked at any occupation since you became disabled, describe work and periods of employment: _____

_____

_____

_____

Name and address of your doctor: _____

_____

Are you receiving Social Security Disability Benefits? ☐ YES ☐ NO
If YES, please attach a copy of your award from Social Security.
If NO, have you applied for Social Security Disability Benefits? ☐ YES ☐ NO
Please attach a copy of your application made to Social Security
If NO, will you be applying for Social Security Disability Benefits? ☐ YES ☐ NO

IF DISABILITY WAS A RESULT OF AN ACCIDENT, COMPLETE THIS SECTION:

Time, Date, Location of injury _____

_____

Describe injury _____

_____

Describe how accident happened _____

_____

_____

The above answers are true and complete to the best of my knowledge. I authorize my attending physician and any hospital to furnish and disclose all facts concerning this disability to A & I Benefit Plan Administrators.

SIGNATURE _____ **DATE**_____

IF YOU ARE APPLYING FOR A DISABILITY PENSION - THIS SECTION MUST BE COMPLETED AND SIGNED BY ATTENDING PHYSICIAN

Patients Name _____

Symptoms _____

_____

_____

Diagnosis _____

_____

_____

HISTORY:

When did symptoms first appear or injury happen? _____

Has patient ever had same or similar condition? ☐ YES ☐ NO If yes, indicate when ____/____/____

Describe _____

ASSESSMENT:

Date you recommended patient should stop working: ____/____/____ Why? _____

_____

_____

Describe the patient's physical and mental limitations and work activity restrictions _____

_____

_____

How long will the described limitations impair the patient?_____

Do you believe this disability to be permanent? ☐ YES ☐ NO Why? _____

_____

TREATMENT:

Planned course of treatment (Please include expected duration, surgeries, therapy, etc.) _____

_____

_____

_____

List other treating or referring physicians (Continue on separate page if necessary):

1. _____ _____

2. _____ _____

3. _____ _____

PROGNOSIS:

Describe the patient's condition since the onset of the symptoms _____

_____

_____

_____

When do you expect a fundamental or marked change in the patient's condition? _____

_____

Date you believe the patient can return to normal work duties _____

Print or type physician's name _____ Degree _____

Address _____

_____

Phone _____

PHYSICIAN'S SIGNATURE _____ **DATE** _____

CHECK LIST OF DOCUMENTS TO SUBMIT WITH APPLICATION

ALL APPLICANTS:

- ☐ Completed application (Pages 1-6 for Disability Retirement). ***If you are currently working, the requested employer information on page 1 must be provided or your benefit will be delayed.***
- ☐ Copy of Birth Certificate or other acceptable documents for proof of age, see list below.
- ☐ Copy of spouse or beneficiary's Birth Certificate or other acceptable documents for proof of age, see list below.
- ☐ If married, a copy of your marriage certificate.
- ☐ If divorced, a court certified copy of all pages of each Divorce Decree(s), Qualified Domestic Relations Order (QDRO), and any attachments, if applicable. Also please complete the enclosed Divorce Questionnaire, page 2.
- ☐ If widowed, a copy of your spouse's death certificate.
- ☐ A copy of your Social Security Disability Award Letter.

LIST OF ACCEPTABLE DOCUMENTS FOR PROOF OF AGE

The acceptable proofs of your age are listed below in two groups. Submit a photo copy of one of the proofs listed in Group 1, if you have it, or can possibly obtain, since this class of proof of age is the more convincing.

If you cannot submit a proof in the Group 1 classification, submit photo copies of two (2) of the proofs listed in Group 2. *

GROUP 1 (Submit one proof)

1. A birth certificate.
2. A baptismal certificate or a statement as to the date of birth shown by a church record, certified by the custodian of such record.
3. Notification of registration of birth in a public registry of vital statistics.
4. Certification of record of age by the U.S. Census Bureau.
5. Hospital birth record, certified by the custodian of such record.
6. A foreign church or government record.
7. A signed statement by the Physician or midwife who was in attendance at birth, as to the date of the birth shown on their records.
8. Naturalization record.
9. Immigration papers.

OR

GROUP 2 (Submit two proofs) *

10. Driver's License
11. Military record.
12. Passport.
13. School records, certified by the custodian of such record.
14. Vaccination record, certified by the custodian of such record.
15. An insurance policy which shows the age or date of birth.
16. Marriage records showing date of birth or age (application for marriage license of church record, certified by the custodian of such record; or marriage certificate.)
17. Other evidence such as signed statements from persons who have the knowledge of the date of birth.
17. Letter from the Social Security Administration stating your date of birth as shown in their records.