**FUND: MICHIGAN BAC PENSION FUND**

**APPLICATION FOR: TOTAL AND PERMANENT DISABILITY BENEFITS**

I hereby apply for **Total and Permanent Disability Benefits** from the Michigan BAC Pension Fund. I understand that eligibility for these benefits is conditioned upon my being an Active Participant at the time I became disabled, my Years of Service since my Effective Date of Participation, and on my physical condition as determined by the Trustees.

I hereby authorize the Board of Trustees or the Administrative Manager of the Fund to obtain from my Physician whatever information deemed necessary to investigate or substantiate my claim for disability hereunder, and I hereby authorize my Physician (whose name and address appear below) to release such information to the Board of Trustees or the Administrative Manager upon written request when accompanied by a photocopy of this application form.

**MY PHYSICIAN IS** (Please type or print):

_____

(First Name) (Middle Initial) (Last Name) (Degree)

_____

(Street Address) (City) (State) (Zip Code)

I hereby submit with this Application, a Physician's Medical Report, completed by my Physician, attesting to my disabled condition, and submit my Birth Certificate and Marriage Certificate (if applicable).

**I UNDERSTAND THAT, IF I HAVE FILED FOR AND RECEIVED A DISABILITY AWARD FROM THE SOCIAL SECURITY ADMINISTRATION, I SHOULD ATTACH A COPY OF IT TO THIS APPLICATION, SINCE IT WILL BE ACCEPTABLE PROOF OF MY DISABILITY.**

**I FURTHER UNDERSTAND THAT IF I HAVE NOT RECEIVED A DISABILITY AWARD FROM THE SOCIAL SECURITY ADMINISTRATION, I SHOULD FILE THIS APPLICATION AS SOON AS MY PHYSICIAN HAS DETERMINED THAT I AM TOTALLY AND PERMANENTLY DISABLED AND SEND IN THE DISABILITY AWARD FROM THE SOCIAL SECURITY ADMINISTRATION WHEN I RECEIVE IT.**

**PERSONAL INFORMATION** (Please type or print):

Name of Applicant:_____

(First Name) (Middle Initial) (Last Name)

Social Security Number: _____Date of Birth: _____

Home Address: _____

(Street) (City) (State) (Zip Code)

Home Telephone Number: _____Present Local Union Number: _____

(***PLEASE COMPLETE OTHER SIDE OF THIS APPLICATION***) Revised: 3/08

Please indicate your marital status, where applicable

☐ Single

☐ Married, number of times

☐ Divorced, number of times or widowed ☐

If currently married, please indicate the following:

Spouse's Name: (First) (Middle) (Last)

Spouse's Social Security Number Date of Birth Married on

Have you ever received benefits from the Michigan BAC Health Care Fund which are related to this disability?

☐ Yes ☐ No

Have you ever received Workers' Compensation Benefits which are related to this disability?

☐ Yes ☐ No

If yes, please submit proof from the time you started collecting Workers' Compensation Benefits through the ending time or through the present (if still collecting), and proof of the weekly rate of benefits. *(You can obtain this information from the insurance carrier who handles your Workers' Compensation.)*

Have you ever worked in the jurisdiction of another Local Union of the International Bricklayers?

☐ Yes ☐ No

If yes, please identify the Local Union(s) as follows:

Local Union No._____ City_____ Year(s) _____

Local Union No._____ City_____ Year(s) _____

Local Union No._____ City_____ Year(s) _____

Last day of work before this disability occurred: _____

Name of Last Employer: _____Employer's Phone No. _____

**I hereby certify that the above information is, to the best of my belief and knowledge, true and complete. Before final action is taken on this application, I understand it will be necessary for me to provide the Trustees of the Pension Fund with a Physician's Medical Report, documentary proof of my Date of Birth, a copy of my Disability Award from the Social Security Administration, if any, and a copy of the Notice of Commencement of Compensation Payments from Workers' Disability Compensation, if applicable:**

**Date:** _____ **Signature of Applicant:** _____

**6525 Centurion Drive, Lansing, MI 48917-9275**
**(517) 3211-7502 • FAX (517) 321-7508**
**www.michiganelectrical.org**

(***PLEASE COMPLETE OTHER SIDE OF THIS APPLICATION***)

**PHYSICIAN'S MEDICAL REPORT**
(To be completed by Applicant's Physician)

**TO: THE BOARD OF TRUSTEES OF THE MICHIGAN BAC PENSION FUND**

RE: Name: _____Social Security Number:_____

Address: _____City:_____State:_____Zip Code:_____

Diagnosis: _____

Concurrent Conditions: _____

When did these symptoms first appear or accident/injury happen? Date: _____

Is the disability due to accident/injury or sickness arising out of the patient's employment? □ Yes □ No

When did the patient first consult you for this condition? Date: _____

How long have you know this patient? Since _____

When did you last examine this patient for this condition? Date: _____

Based on your examination of and conversation with the patient,

Was the disability contracted, suffered or incurred while he/she was engaged in or the result of his/her having engaged in a criminal enterprise? □ Yes □ No

Was the disability self-inflicted? □ Yes □ No

Is this patient totally unable to engage in his/her regular occupation or employment for remuneration or profit as the result of this disability? □ Yes □ No

As of what date did this occur? Date: _____

Do you consider this disability to be permanent? □ Yes □ No

If no, what is the probable future duration? _____

_____

(***PLEASE COMPLETE BOTH SIDES OF THIS REPORT)*** Revised 2/07

Is this patient totally unable to engage in his/her regular occupation or employment at the bricklayer's trade as the result of this disability? □ Yes □ No

As of what date did this occur? _____

Do you consider this disability to be permanent? □ Yes □ No

If no, what is the probable future duration? _____

_____

What employment can this patient engage in? _____

_____

What employment is this patient restricted from? _____

_____

_____

Physician's Signature: _____

Please type or print the following:

Physician's Name: _____

Address: _____

City: _____State: _____Zip Code: _____

Telephone Number: _____
(Area Code)

Date_____

**MICHIGAN BAC PENSION FUND**
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**Lansing, MI 48917-9275**
**(517) 321-7502 • FAX (517) 321-7508**
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(***PLEASE COMPLETE BOTH SIDES OF THIS REPORT)*** Revised 2/07