

**PLUMBERS & PIPEFITTERS LOCAL 101 HEALTH & WELFARE FUND
DEATH BENEFIT
WAIVER OF PREMIUM**

While you are covered, if you become totally disabled before you reach the age of 60 and coverage for death benefits would otherwise terminate, a death benefit will nevertheless be payable if you die before reaching age 65, provided the total disability began while you were covered under this plan, you have been totally disabled for nine consecutive months, you remain continuously disabled until death, and you submit written proof of the disability within 12 months of the date your coverage would terminate and each year thereafter.. Based on your current disability status, you may be entitled to this benefit.

To apply for this extended coverage, please complete the Employee's Statement of Claim and have your doctor complete the Physician's Statement of claim on the reverse side and return to **Benefit Consultants, Inc., 13515 Barrett Parkway Drive, Suite 265, Ballwin, MO 63021.**

Statement of Participant		
Name		
Address		
City:	State:	Zip:
Date of Birth:	Social Security Number:	Telephone Number:
Date Last Reported to Work:	Date you expect to return: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	
Date of First Medical Treated for this Disability:	Are you engaged in any other gainful employment? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	
Are you currently seeking vocational assistance or retraining for another occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been approved for Social Security Disability Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List Name, Address and Phone Number of physicians that have treated you for this sickness or injury.		
List Name and Address of hospitals confined to during this disability:		
<p>Certification and Authorization for Release of Information:</p> <p>I hereby certify that the above information is true and correct to the best of my knowledge. I understand that falsification or withholding of material facts may result in loss of benefits.</p> <p>For the purpose of determining eligibility and claim processing, I hereby authorize Benefit Consultant, Inc., to receive from and/or provide to medical practitioners, medically –related facilities, insurance companies or like organizations, or my employer, information as to any physical or mental condition of myself or my covered dependents.</p> <p>I know that I have a right to receive a copy of this authorization. I agree a photographic copy is as valid as the original.</p>		
<hr style="width: 80%; margin-left: 0;"/> Signature of Insured	<hr style="width: 80%; margin-left: auto; margin-right: 0;"/> Date	

Statement of Physician

Name of Patient:

Date of Birth:

Nature of Medical Impairment/Limitations:

Primary Diagnosis:

Secondary Diagnosis::

When did symptoms first appear or accident happen?

Date Patient ceased work because of disability?

Is injury or illness work related? Yes NoHas patient ever had same or similar condition? Yes No
If yes, describe:

Date of last examination?

Nature of treatment (including surgery and medications prescribed):

Progress

Has patient Recovered Improved Unchanged Retrogressed
 Is patient Ambulatory House Confined Bed Confined Hospital Confined
 Has patient been hospital confined? Yes No
 If yes, give name and address of hospital
 Confined from _____ through _____

Cardiac (if applicable)

Functional capacity: Class 1 (no limitation) Class 2 (slight limitation) Class 3 (marked limitation) Class 4 (complete limitation)
 Blood pressure (last visit) Systolic _____/Diastolic _____

Physical Impairment

- Class 1—No limitation of functional capacity, capable of heavy work. No restrictions. (0-10%)
 Class 2—Medium manual activity (15-30%)
 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%)

Mental/Nervous Impairment (if application)

Define stress as it applies to this applicant.

What stress and problems in interpersonal relations has claimant had on job?

- Class 1—No limitations—Patient is able to function under stress and engage in interpersonal relations
 Class 2—Slight limitations—Patient is able to function in most stress situations and engage in only limited interpersonal relations
 Class 3—Moderate limitations—Patient is able to engage in only limited stress situations and only limited interpersonal relations
 Class 4—Marked limitations—Patient is unable to engage in stress situations or engage in interpersonal relations
 Class 5—Severe limitations—Patient has significant loss of physiological, psychological, personal and social adjustment

Remarks:

Prognosis/Rehabilitation

Is patient now totally disabled? Patient's job: Yes No Any other work: Yes No
 If no, when is patient able to go to work? Patient's job: _ Any other work:
 If yes, will this disability prevent the patient from engaging in any meaningful occupation for the remainder of his/her life? Yes No
 What duties of patient's job is he/she incapable of performing?

Do you expect a fundamental or marked change in the future? Patient's job: Yes No Any other work: Yes No
 If yes, when do you think patient will be able to resume work? Patient's job: _ Any other work:
 Is patient a suitable candidate for further rehabilitation services? Yes No
 Would job modification enable patient to work with impairment? Yes No
 When could trial employment commence: Patient's job: Full Time Part Time
 Any Other Work Full Time Part Time
 Would vocational counseling and/or retraining be recommended? Yes No

Name of Physician:

Degree/Specialty:

Address:

I certify that the information provided is accurate and complete.

Signature of Physician

Date