

**UPPER PENINSULA PLUMBERS' & PIPEFITTERS' PENSION FUND AND THE  
UPPER PENINSULA PLUMBERS' AND PIPEITTERS' DEFINED CONTRIBUTION PLAN  
APPLICATION FOR TOTAL AND PERMANENT DISABILITY BENEFITS**

I hereby apply for **Total and Permanent Disability Benefits**. 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 PHISICIAN IS: (Please type or print):**

\_\_\_\_\_

(Physician's First, middle and last names)

\_\_\_\_\_

(Degree)

\_\_\_\_\_

(Physician's Complete physical address)

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 and a complete copy of my final Judgment of Divorce (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.**

**APPLICANT PERSONAL INFORMATION (Please type of print):**

\_\_\_\_\_

(First, middle and last names)

\_\_\_\_\_

(Social Security Number, NNN-NN-NNNN)

\_\_\_\_\_

(Date of Birth, MM/DD/YYYY)

\_\_\_\_\_

(Complete physical address)

\_\_\_\_\_

(Home Phone, NNN-NNN-NNNN)

\_\_\_\_\_

(Present Local Union Number)

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Please indicate your marital status, where applicable:

Single

Married, number of times \_\_\_\_\_

Divorced, number of times \_\_\_\_\_ or widowed \_\_\_\_\_

Last day of work before this disability occurred (MM/DD/YYYY): \_\_\_\_\_

Name of Last Employer: \_\_\_\_\_

Last Employer's Phone (NNN-NNN-NNNN): \_\_\_\_\_

**MAILING INSTRUCTIONS** (Complete only if different than the "Home Address" shown on other side):

Mail Benefit Check to: \_\_\_\_\_  
(First, middle and last names)

\_\_\_\_\_  
(Complete physical address)

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:

\_\_\_\_\_  
(Applicant signature)

\_\_\_\_\_  
(Date signed, MM/DD/YYYY)