ILWU-PMA PENSION PLAN • ILWU-PMA WATCHMEN PENSION PLAN

DISABILITY RETIREMENT MEDICAL REPORT

DOCTOR'S CONTACT INFORMATION:

NAME:
ADDRESS:
CITY, STATE, ZIP:
PHONE NUMBER:

☐ Kaiser Health Plan

☐ Indemnity Plan

PLEASE SUBMIT COMPLETED FORM VIA MAIL, FAX, OR EMAIL:

ILWU-PMA BENEFIT PLANS - 1188 FRANKLIN STREET - SUITE 101 - SAN FRANCISCO, CA 94109
FAX#: (415) 749-1321 ◈ EMAIL: pension@benefitplans.org

PATIENT NAME ______________________ **LOCAL** __________ **REG. NO.** __________

TO BE COMPLETED BY ATTENDING PHYSICIAN. PLEASE ANSWER ALL QUESTIONS:

1) Is the patient totally and permanently disabled for his/her regular work in the Longshore or Watchmen industry? .... YES☐ NO ☐

   a) **IF YES**, on what date did patient become totally and permanently disabled for his/her regular work? ______________________

   b) On what date did you reach this conclusion? ______________________

2) Is the disability wholly attributable to an industrial injury? .... YES ☐ NO ☐

3) On what date, according to your records, did illness begin or the disabling injury occur? ______________________

4) Is treatment continuing? ______________________

5) Date patient last seen? ______________________

6) Completely describe in the space below a summation of medical condition, diagnoses, and the physiological limitations or impairment.

OR

7) Submit written documentation (narrative, medical summaries, legible office notes, pertinent laboratory and/or test results, etc.) that provide the medical reviewer with sufficient information to make an independent decision.

   ☐ **CHECK BOX IF DOCUMENTS ARE ATTACHED**

Examining Doctor: ______________________

PRINT NAME **SIGNATURE** **DATE**

TO BE COMPLETED BY PENSION PLAN REVIEWING DOCTOR:

☐ I concur with the conclusions of the examining doctor.
☐ I do not concur with the conclusions of the examining doctor.

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Signature of Plan Reviewing Doctor **Date**

PATIENT'S RELEASE

I hereby authorize the release of information from and concerning my medical records to the ILWU-PMA Pension Plan or ILWU-PMA Watchmen Pension Plan Trustees, their agents, their consulting physicians and my ILWU Local.

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Signature of Patient (Retirement Applicant) **Date**

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