

Trust Fund Office
 Laborers Health & Welfare Trust Fund For Southern California
 1123 Park View Drive, Suite 200 • Covina, California 91724
 P.O. Box 3389 • Covina, California 91722-5389
 T (626) 279-3000 • 1 (800) 887-5679 • F (626) 279-3094
 www.socalaborers.org

Application for Disability Freeze Benefits for Active Members

Employee: Complete Part I. Please answer all questions fully to help expedite the evaluation of your claim.

- Remember to sign and date the Fraud Statement.
- Ask your physician to complete Part II.

Part I and Part II should be returned at the same time to the Trust Fund Office within 30 days to the address listed below:

Mail both (Part I and Part II) Statements to:

Laborers Health & Welfare Trust Fund For Southern California
 P.O. Box 3389
 Covina, CA 91722-5389

PART I – EMPLOYEE’S/MEMBER’S STATEMENT

First Name		M.I.	Last Name	Social Security Number	
Date Of Birth (Mo/Day/Year)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Mailing Address				Apt. Number	
City		State	Zip Code	Telephone No.	
Occupation	Local Union	Date Last Worked (Month / Day / Year)		Are You Entitled to Any Of The Following Benefits: <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Social Security Disability	
Date Accident Or Illness Began: (Month / Day / Year)					
Date First Treated By Physician For Disability: _____ (Provide Month / Day / Year)					
Were You Injured At Your Job? <input type="checkbox"/> No <input type="checkbox"/> Yes		(If Injured, How, When And Where Did Accident Happen?)			
Have you applied for Social Security Disability: <input type="checkbox"/> Yes: Month ____ Year ____ <input type="checkbox"/> No			Have You Filed A Disability Freeze Previously? <input type="checkbox"/> Yes: Month ____ Year ____ <input type="checkbox"/> No		

LB Disability Freeze App._Rev. June 5, 2017



PART I – EMPLOYEE’S/MEMBER’S STATEMENT (CONTINUED)

Employee's Telephone Number _____

Name, Address And Telephone Number Of Each Physician Who Treated You For Your Disability

Misrepresentation And Fraud

In the event you or any **Member/Employee** receives benefits because of any misleading or fraudulent representations to the Plan, you will be liable to repay all amounts paid by the Fund. Fraud includes failure to disclose any information regarding other group health coverage under the Plan’s coordination-of-benefits provisions or failure to disclose information regarding no-fault automobile coverage, Workers’ Compensation or third-party liability under the Fund’s Equitable Lien and Subrogation provisions. Furthermore, the Board of Trustees must ensure that all who benefit from the Plan do so appropriately and only as they are entitled. For example, if the Trustees determine that an Employee, his dependents, or health care provider has made any misrepresentation (whether or not intentional) in connection with claims for benefits or has committed any act or omission resulting in abuse or misuse of the Plan, the Board of Trustees reserves the right and authority to impose upon Employees and their Dependents restrictions with respect to their future rights to receive benefits from the Trust. The Trustees reserve the right to seek reimbursement and other damages, together with attorney’s fees (to the extent provided by law) and other costs incurred in connection with recovering any benefits incorrectly paid, or not reimbursed, when reimbursement is required under the Plan. To be reimbursed for benefits improperly paid, the Trustees may also exercise a right of offset against future benefits payable on behalf of the Employee and his Dependents. In addition to the specific circumstances set forth elsewhere in this document in which the Trustees may suspend the payment of benefits to a participant or a beneficiary, the Trustees shall also have the general power to withhold and offset such benefits for claims incurred on behalf of the any participant or beneficiary who:

1. owes money to the Trust because of any obligations imposed upon them by this Plan booklet or the rules and regulations of the Trust, or
2. owes money to the Trust because the Trust overpaid a participant or beneficiary, or
3. in any other circumstances in which a participant or beneficiary legally owes money to the Trust.

The Trustees also reserve the right to refuse payment for services rendered or facilities or supplies furnished by particular health care providers. These powers may be used as the Trustees deem necessary.

THESE STATEMENTS IN PART 1 ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

(PRINT) NAME OF EMPLOYEE/MEMBER

SIGNATURE OF EMPLOYEE/MEMBER

DATE

PART II – PHYSICIAN'S STATEMENT

Mail both Part I and Part I Statements to Laborers Health & Welfare Trust Fund For Southern California
P.O. Box 3389, Covina, CA 91722-5389

Name of Patient			Social Security Number
Address			Date of Birth (Mo/Day/Year)
City	State	Zip Code	

HISTORY OF INJURY OR ILLNESS

When did symptom first appear or disability happen?	Month	Day	Year
Date patient was unable to work because of disability?	Month	Day	Year

Has patient ever had same or similar condition?

No.

Yes, Month___ Day___ Year___ (If yes, describe similar condition below.)

Description of similar condition.

Names and addresses of other treating physicians:

DIAGNOSIS

Diagnosis (including any complications): _____

ICD10 Code: _____

Subjective symptoms:

Objective findings (clinical notes and surgical reports are not necessary):

DATES OF TREATMENT

Date of first visit: Date of last visit: Frequency weekly monthly
Month___ Day ___ Year Month___ Day ___ Year Other (specify) _____

NATURE OF TREATMENT (including any medications prescribed, if any)

PROGRESS

Patient has Recovered Improved Unchanged Retrogressed

Patient is Ambulatory House Confined Bed Confined Hospital Confined

PART II – PHYSICIAN'S STATEMENT (CONTINUED)

HOSPITALIZATION

Has patient been hospital confined? Yes No If "Yes", hospital name _____

Address _____ Confined from _____ through _____

PHYSICAL IMPAIRMENT (*as defined in Functional Dictionary of Occupational Titles)

Class 1 – No limitation of functional capacity of heavy work *No restrictions (0 -10%)

Class 2 – Medium manual activity *(10-30%)

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%)

Remarks: _____

PROGNOSIS

What are the patient's current restrictions and limitations?

When was patient able to resume work? (If unknown, provide estimated date) Month ___ Day ___ Year ___

Do you expect a fundamental or marked change in the future including improvement and/or deterioration?

Yes No

1 Month 1-3 Months

3-6 Months Indefinitely

Never

REHABILITATION

Is patient a suitable candidate for further rehabilitation services? Yes No
(For example, cardiopulmonary program, speech therapy if meets the Plan's rules.)

REMARKS

THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF

(Print) Name of Treating Physician completing this form

Degree/Specialty

Tax ID Number

Address

City

State

Zip Code

Telephone Number

Fax Number

Signature of Treating Physician

