Teamsters Pension Trust Fund

of Philadelphia and Vicinity

2500 MCCLELLAN AVE, SUITE 140 • PENNSAUKEN, NJ 08109 • (856) 382-2400
TOLL-FREE (800) 523-2846 • FAX (856) 382-2401 • www.teamsterfunds.com

Dear Member:

Enclosed is a preliminary application to apply for Disability Retirement benefits. This application does not guarantee benefits from the Fund, your eligibility to receive Retirement benefits will be reviewed once all information is received. Please read and follow the instructions listed below:

1. Answer all questions in the spaces provided.
2. Page 4 needs to have your signature notarized.
3. Please provide all copies (if applicable) of: your birth certificate, your spouse's birth certificate, your marriage certificate, your social security card and your spouse's social security card. A baptismal certificate may be substituted for a birth certificate.
4. Military Discharge papers (DD-214), only required if military service was served while in Covered Employment.
5. Submit a copy of your Social Security Disability Award or if applicable, your denial letter. If you are still awaiting your decision from the Social Security Administration, or if you were denied, please submit a copy of your medical records pertaining to your disability.
6. Have your physician, who is treating you for your disability, complete the Physician's statement.

Your entire application and all requested documents must be returned before we can begin processing your retirement application. Most applications require 60 – 90 days to process. If we need to contact you regarding your application or if we require additional information, we will do so by mail.

If you should have any questions regarding this matter, please do not hesitate to contact the Pension Department at 1-800-523-2846.

Sincerely,

Teamster Pension Trust Fund
of Philadelphia and Vicinity

Teamsters Pension Trust Fund of Philadelphia & Vicinity
Application for Disability Retirement Benefits

Date: _____

Member/Spouse Information

Please read all questions carefully and print your answers

(1) Member's Name: _____
Last First Middle Initial

(2) Social Security #: _____ *Attach copy of Social Security Card*

(3) Member's Address: _____

_____ Member's Phone #: _____

Member's cell phone #: _____ Member's email: _____

(4) Member's Date of Birth: _____ *Attach copy of Birth Certificate*

(5) Intended Retirement Date: (Month/Day/Year) _____

(6) Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ (check one box only)

Note: If you are currently ***Divorced* or ***Widowed***, you must attach a full copy of your divorce decree with any property settlement agreement that might be attached or your spouse's death certificate.**

(7) Spouse's Maiden Name: _____
Last First Middle Initial

If spouse's maiden name is different than indicated on the Marriage Certificate, please attach appropriate documents to substantiate each name change.

(8) Spouse's Social Security#: _____ *Attach copy of Social Security Card*

(9) Spouse's Date of Birth: (Month/Day/Year) _____ *Attach copy of Birth Certificate*

(10) Date of Marriage: (Month/Day/Year) _____ *Attach copy of Marriage Cert.*

Teamsters Membership

(List each period of membership beginning with the most recent.)

Local Union #	City and State	Periods of Membership – FROM	TO

Employment History

List all Employment, beginning with your most recent employer.

Name and Address of Employer	Type of Work Performed	Periods of Employment From To

If you need additional space, please use the back of this page.

(11) Last Day of Work:_____

(12) Current Employer:_____

(13) Address and Telephone # of Current Employer:_____

_____.

(14) Number of hours you ***currently*** work each month: _____Date you plan to terminate this ***current*** employment:_____.

(15) Have you ever been a member of the Local Union but were not working in Covered Employment, you were self-employed or not actively employed for any reason?_____

_____

(16) If so, reason you were not in Covered Employment:_____

(17) Time period you were not in Covered Employment:_____

Military Service

(18) Have you ever served in the U.S. Military?_____

Dates of Service: To:_____ From:_____

Attach a copy of discharge or separation papers if time served was while you were in Covered Employment.

Record of Disability Benefits

(19) Have you ever received Weekly Disability Benefits?_____

(20) If so, when?(*list all dates*)_____

(21) Have you ever received Workmen's Compensation Benefits?_____

(22) If so, when?(*list all dates*)_____

(23) Have you applied for Social Security Disability Benefits?_____

(24) Have you been approved or denied Social Security Disability Benefits?_____

(25) If approved, when?_____ *Attach copy of Social Security Disability Award*

(26) List the name and address of each physician you have seen due to your disability.

Name and Address of Physician ***Periods of Treatment***

_____

_____

_____

_____

_____

_____

_____

_____

If you need additional space, please use the back of this page.

I hereby apply for a **Disability** Retirement Pension from the Teamsters Pension Trust Fund of Philadelphia and Vicinity. I, being duly sworn, attest that I have read and understand the foregoing statements and my answers and information therein contained and that the same are true and correct to the best of my knowledge and belief.

_____

Member's Signature ***(Signature must be notarized or witnessed by a Plan representative)*** Date

_____

Fund Representative (witness) Date

Sworn before me this _____day of _____, _____.
Day *Month* *Year*

_____

Notary Public

Please return a ***copy*** of the items marked with a ✓.

Member's Birth Certificate:_____

Spouse's Birth Certificate:_____

Member's Social Security Card:_____

Spouse's Social Security Card:_____

Divorce Decree:_____

Property Settlement Agreement:_____

Marriage Certificate:_____

Death Certificate:_____

Spouse's Name change verification: _____

All documents already on file:_____

Social Security Disability Award: _____

Medical Records:_____

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Application for Disability Retirement Benefits

Attending Physician's Statement (to be completed by physician)

Please answer all the questions listed below. This information will be used to assist the Fund in determining the member's eligibility for a Disability Pension. This statement is to be furnished without expense to the Fund.

Member's Name (applicant):_____

How long have you been the applicant's medical advisor:_____
Month Day Year

When did the applicant's present illness or injury occur:_____
Month Day Year

When did the applicant stop working due to his/her illness or injury:_____

Does the applicant have a history of this illness or injury: (yes or no)_____

Please list the applicant's **diagnosis, symptoms** and **prognosis** for his/her present condition:_____

_____

_____

_____

Do you believe, as the applicant's attending physician, that this member is **Totally and Permanently disabled, unable to perform any type of work for wage or profit for the remainder of their lifetime?**

☐ **Yes** (applicant's name)_____ is Totally and Permanently Disabled unable to perform any type of work for wage or profit for the remainder of their lifetime.

☐ **No** (applicant's name)_____ is not Totally and Permanently disabled.

Is the applicant any of the following: ☐ Ambulatory ☐ Confined to Bed ☐ Confined to Home
☐ Hospitalized

Please indicate from what date:_____

In your opinion, will the applicant be expected to return to any type employment? If yes, when?___

_____

If this disability involves a mental condition, is the applicant competent to endorse checks and direct use of the proceeds with a clear understanding of the nature of his/her acts:_____

Signature of Physician_____ Date_____

Print Physician's name_____

Physician's address_____