Alaska Laborers-Employers Retirement Trust Fund

P.O. Box 34203 • Seattle, WA 98124
Phone (855) 815-2323 • Fax (907) 561-4802
Website: www.aklaborerstrust.com
Administered by WPAS, Inc.

TOTAL AND PERMANENT DISABILITY QUESTIONNAIRE

Employee's Statement:

Name *(Last, First, Middle Initial)*	Birth Date *(M/D/Y)*	Social Security Number
Mailing Address *(Street, City, State, Zip)*		
( ) Home Phone No.	( ) Cell Phone No.	Email Address

1. Date last worked at any employment: _____
2. Was your disability caused by a work related disease or injury? _____
3. Have you filed a Claim for Worker's Compensation? _____
   a. If "yes", state Claim Number _____
4. Have you filed for Social Security Disability benefits? _____
   a. Has your claim been approved? _____
5. Please list the name, address and telephone number of doctor seen for this disability:
   Name: _____
   Phone Number: _____
   Address *(Street, City, State, Zip):* _____
6. Please list name and address of any hospital to which confined in the past 12 months:
   Name: _____
   Phone Number: _____
   Address *(Street, City, State, Zip):* _____
7. Have you worked at ANY occupation since disability commenced? ☐ Yes ☐ No
   a. If "yes", please list occupation: _____
   b. If "yes", please list name and address of employer:
      Name: _____
      Phone Number: _____
      Address *(Street, City, State, Zip):* _____
8. Are you engaged in any rehabilitation? ☐ Yes ☐ No
   a. If "yes", please describe job responsibilities or title, hours worked, name and address, and telephone number of Employer:
      Job responsibilities or Title: _____
      Hours Worked: _____
      Employer's Name: _____
      Employer's Phone No.: _____
      Employer's Address *(Street, City, State, Zip):* _____

I hereby certify that the foregoing statements, including any accompanying statements, are true, correct and complete to the best of my knowledge and hereby further authorize my attending physician, practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization that has facts concerning my medical care or physical condition to disclose, whenever requested to do so by Labor Trust Services, Inc. any and all such information. A photo copy of this authorization shall be considered as effective and valid as the original.

Employee Signature_____ Date_____

HAVE PHYSICIAN COMPLETE THE SECOND PAGE

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Attending Physician's Statement

Patient's Name: _____ Age: _____

Date First Treated: _____ Date Last Treated: _____

Diagnosis:

Frequency of Care? ☐ Weekly ☐ Monthly ☐ Annual ☐ Other

Symptoms are? ☐ Progressive ☐ Stationary ☐ Improving

Based on medical evidence, do you believe this patient is TOTALLY AND PERMANENTLY disabled and prevented from performing duties of HIS/HER occupation? ☐ Yes ☐ No

Based on medical evidence, do you believe this patient is TOTALLY AND PERMANENTLY disabled and prevented from performing the duties of ANY occupation for which he/she may be qualified by reason of training or experience? ☐ Yes ☐ No

Comments:

Date TOTAL AND PERMANENT disability commenced? _____

This disability ☐ does or ☐ does not result from one of the following: Self-inflicted injury, habitual use of narcotics or habitual use of alcoholic beverages. If it does, please explain:

Remarks:

Date: _____ Signed: _____, M.D.

T.I.N.: _____

S.S.N.: _____ Address: _____