

NAME OF CEMENT MASON _____ SOCIAL SECURITY NO. _____

I PHYSICIAN MUST COMPLETE (Please Type or Print)

TO: Cement Masons Health & Welfare Trust Fund for Northern California

This is to certify that the above named was absent from Covered Employment as a Cement Mason due to disability for the period from _____ to _____

Nature of Disability (is) (was) _____

Date you first examined patient for above condition _____

Date: _____ Physician's Signature _____

Telephone No. _____ Physician's Name (print) _____

Physician's Address _____
STREET CITY STATE ZIP

II CEMENT MASON MUST COMPLETE

(This portion should be completed by the Cement Mason ONLY if he received Worker's Compensation or State Disability Insurance during the above disability period.)

TO: Cement Masons Pension Trust Fund of Northern California

The undersigned certifies:

1. That said disability (is) (was) occupational non occupational. (Check one)
2. That _____ benefits have been paid.
(WORKER'S COMPENSATION OR STATE DISABILITY INSURANCE)
3. That if Worker's Compensation benefits were paid, they were Temporary Disability benefits _____ or Permanent Disability benefits _____. (check one)
4. That the insurance carrier or other agency making payments described in Item No. 2 above (is) (was) _____
5. That said payments have been paid from _____ to _____
6. That the nature of the disability (is) (was) _____
7. That the last date I worked as a Cement Mason prior to my Disability was _____

III CEMENT MASON'S AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Claim cannot be processed unless signed)

The undersigned patient hereby authorizes any provider of health care, physician or other practitioner, hospital, insurer, self-insurer, consumer reporting agency, employer, union or other labor organization or group policy holder to furnish and disclose to the Cement Masons Health and Welfare Trust Fund for Northern California and the Cement Masons Pension Trust Fund for Northern California, or any person or entity representing such Fund, all records or other information in their control or within their knowledge concerning his medical history, physical or mental condition, or any consultation, prognosis, diagnosis or treatment, for use solely in the processing of the within claim, including any procedure for the coordination of benefits or for reciprocity. The undersigned also hereby authorizes such Fund or any person or entity representing such Fund, to acquire, possess, utilize and disclose such information for such purpose, including the disclosure thereof to any provider of health care, insurer, self-insurer, hospital, health care service plan or employer, union, or other labor organization, or any person or entity representing any of the foregoing. This authorization shall remain valid until the claim has been fully processed, including any procedures for review or investigation of the claim after payment. The undersigned understands that he has the right to receive a true copy of this signed authorization upon demand. This authorization is intended to be a valid authorization pursuant to California Civil Code Section 56.10 and shall be construed to give effect to this intention. A photocopy of this authorization shall be as valid as the original.

Date Signed _____ Cement Mason's Signature _____
(Cement Mason must sign personally)

IV CEMENT MASON MUST COMPLETE AND SIGN

Executed on this _____ day of _____ 19____, at _____, California.

The undersigned declares under penalty of perjury that the foregoing is true and correct.

Cement Mason's Signature _____

Telephone No. _____ Address _____
STREET

Local Union No. _____ CITY STATE ZIP

This is NOT an application for a pension

