



# OPERATIVE PLASTERERS' & CEMENT MASONS' LOCAL UNION #518 FRINGE BENEFIT FUNDS

Managed for the Trustees by:  
**TIC INTERNATIONAL CORPORATION**

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## APPLICATION FOR DISABILITY HOURS

NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

ADDRESS \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_

If disability is the result of an accident, please complete:

- Date accident occurred \_\_\_\_\_
- Were you at work when the accident occurred? \_\_\_\_\_
- Describe accident (how, when and where occurred) \_\_\_\_\_

Have you returned to work? \_\_\_\_\_ If yes, when? \_\_\_\_\_

If not, when do you expect to be able to return \_\_\_\_\_

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_

## ATTENDING PHYSICIAN OR SURGEON'S STATEMENT

PATIENT'S NAME \_\_\_\_\_

Nature of sickness or injury \_\_\_\_\_

Date of first treatment \_\_\_\_\_

Frequency of treatments \_\_\_\_\_

Patient has been continuously disabled (unable to work):

From \_\_\_\_\_ To \_\_\_\_\_

If still disabled, when should patient be able to return to work? \_\_\_\_\_

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_

Degree \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_