Heat and Frost Insulators Local #34 Pension Plan

Return completed forms to the Fund Office:

Wilson-McShane Corporation
3001 Metro Drive- Suite 500, Bloomington, MN, 55425
952-851-5948 or 1-800-535-6373

Certification of Disability

Completion of this Form is only required if you are applying for a distribution due to disability.

Name _____
Last First Middle

SSN ____ ____ ____ - ____ ____ - ____ ____ ____ ____ Date of Birth _____ /_____ /_____

Last Day Worked (In Covered Employment) _____ /_____ /_____ Date of Exam _____ /_____ /_____

Part II - Medical Doctor Attestation

The above-named individual has applied for disability benefits from the Heat and Frost Insulators Local #34 Pension Plan ("the Plan"). The Plan requires a written certification of disability as a prerequisite to receiving disability benefits.

For purposes of the Plan, "disability" means that the participant suffers from a mental or physical condition resulting from bodily injury, disease, or mental disorder which makes the participant incapable of performing the customary duties of his/her position for an indefinite period of time expected to last at least twelve (12) months.

The types of work and movement included in the individuals job duties are:

- Lifting 25 pounds or more on a consistent basis
- Bending
- Stooping
- Climbing scaffolding and/or ladders
- Working above his/her head

Given the above, in your opinion, does the participant have a disability as defined by the Plan?

☐ **Yes** ☐ **No**

Part III – Medical Doctor Signature

I certify that this Certification of Disability has been read and is true to the best of my medical knowledge, after reasonable examination.

_____
Doctor's Signature Doctor's Name, PRINTED Date

Doctor's Address:

_____

_____

_____

Doctor's Phone Number:

_____

PLEASE NOTE:

- **The above terms are SPECIFIC and MUST be responded to with a definite "Yes" or "No".**
- **No modification or clarification is acceptable.**