

ILWU-PMA PENSION PLAN • ILWU-PMA WATCHMEN PENSION PLAN
DISABILITY RETIREMENT MEDICAL REPORT

DOCTOR'S CONTACT INFO:

Kaiser Health Plan

NAME:

ADDRESS:

Indemnity Plan

CITY, STATE, ZIP:

PHONE NUMBER:

PLEASE SEND COMPLETED ORIGINAL FORM TO:

ILWU-PMA BENEFIT PLANS - 1188 FRANKLIN STREET - SUITE 101 - SAN FRANCISCO, CA 94109

PATIENT NAME

LOCAL

REG. NO.

TO BE COMPLETED BY ATTENDING PHYSICIAN. PLEASE ANSWER ALL QUESTIONS:

- 1) Is the patient totally and permanently disabled for his regular work in the longshore or watchmen industry? YES NO
 - a) IF YES, on what date did patient become totally and permanently disabled for his regular work? _____
 - b) On what date did you reach this conclusion? _____
- 2) Is the disability wholly attributable to an industrial injury? YES NO
- 3) On what date, according to your records, did illness begin or the disabling injury occur? _____
- 4) Is treatment continuing? _____
- 5) Date patient last seen? _____
- 6) Completely describe in the space below a summation of medical condition, diagnoses, and the physiological limitations or impairment.

OR

- 7) Submit written documentation (narrative, medical summaries, legible office notes, pertinent laboratory and/or test results, etc.) that provide the medical reviewer with sufficient information to make an independent decision.

CHECK BOX IF DOCUMENTS ARE ATTACHED

Examining Doctor: _____
PRINT NAME SIGNATURE DATE

TO BE COMPLETED BY PENSION PLAN REVIEWING DOCTOR:

- I concur with the conclusions of the examining doctor.
- I do not concur with the conclusions of the examining doctor.

Signature of Plan Reviewing Doctor _____ Date

PATIENTS' RELEASE

I hereby authorize the release of information from and concerning my medical records to the ILWU-PMA Pension Plan or ILWU-PMA Watchmen Pension Plan trustees, their agents, their consulting physicians and my ILWU Local.

Signature of Patient _____ Date

