



**CENTRAL STATES  
SOUTHEAST AND  
SOUTHWEST AREAS  
PENSION FUND**

**APPLICATION FOR DISABILITY BENEFIT  
(See instruction booklet)**

PRINT OR TYPE ALL INFORMATION

APPLICATION DATE \_\_\_\_\_

**Section 1 - PARTICIPANT INFORMATION**

This statement must be fully answered by the claimant or, if the claimant is mentally or physically incompetent, his appointed guardian or conservator or anyone legally empowered to do so.

a. PARTICIPANT SOCIAL SECURITY NO.	CODE <b>6</b>	b. LAST NAME	FIRST	M.I.	c. SEX	d. IF FEMALE, MAIDEN NAME
e. ADDRESS		CITY		STATE	ZIP CODE	
f. AREA CODE ( )	PHONE NO. -	g. DATE OF DISABILITY	MONTH	DAY	YEAR	h. TEAMSTER LOCAL UNION NO.
i. DATE OF BIRTH	MONTH	DAY	YEAR	j. ATTACH PROOF OF AGE		
k. MARITAL STATUS (CHECK ONE)		<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED	
l. PRESENT OR MOST RECENT TEAMSTER EMPLOYER			ATTACH COPY OF MARRIAGE CERTIFICATE OR DIVORCE PAPERS			
m. IS THIS DISABILITY A RESULT OF (CHECK ONE)		<input type="checkbox"/> ILLNESS?	<input type="checkbox"/> INJURY?	<input type="checkbox"/> JOB RELATED INJURY?	DATE OF INJURY _____	
n. ARE YOU RECEIVING BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION?		YES <input type="checkbox"/>	IF YES, ATTACH COPY OF ENTIRE AWARD			
		NO <input type="checkbox"/>	IF NO, DATE APPLIED FOR _____			
IF THE AWARD IS OVER ONE YEAR OLD ALSO ATTACH A COPY OF YOUR MOST RECENT DISABILITY CHECK. IF AN AWARD WAS DENIED ATTACH A COPY OF THE DENIAL.						

**Section 2 - SPOUSE/FAMILY INFORMATION**

a. SPOUSE'S SOCIAL SECURITY NO.	b. LAST NAME	FIRST	M.I.	c. IF FEMALE, MAIDEN NAME
d. DATE OF BIRTH	MONTH	DAY	YEAR	e. ATTACH PROOF OF SPOUSE'S AGE

LIST BELOW THE FULL NAMES OF ALL LIVING CHILDREN: (IF NO SPOUSE OR CHILDREN, NEAREST RELATIVE)

f. NAME SOCIAL SECURITY NUMBER	g. ADDRESS (City, State, ZIP Code)	h. BIRTHDATE			i. RELATIONSHIP
		MONTH	DAY	YEAR	

**Section 3 - EXTENT OF DISABILITY**

ANSWER THE FOLLOWING THREE QUESTIONS FULLY:

a. To what extent are you able to work?

b. On what date was it necessary to give up all of your duties?	<b>MONTH</b>	<b>DAY</b>	<b>YEAR</b>

c. Have you done any type of work since your disability? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please include employment information in Section 6.
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**Section 4 - LOCAL UNION MEMBERSHIP**

INDICATE PERIOD OF MEMBERSHIP IN ALL LOCAL UNIONS, STARTING WITH THE MOST CURRENT.

a. LOCAL NO.	b. TEAMSTER?		c. LOCATION (CITY AND STATE)	d. PERIOD OF MEMBERSHIP			
	YES	NO		FROM		TO	
				MONTH	YEAR	MONTH	YEAR

**Section 5 - EMPLOYMENT HISTORY**

LIST ALL EMPLOYMENT BEGINNING WITH YOUR PRESENT OR MOST RECENT EMPLOYER. LIST ONLY YOUR EMPLOYMENT AS AN EMPLOYEE. BE SURE TO INCLUDE THE COMPANY LISTED IN SECTION 1, PART L. ALSO, BE SURE TO INCLUDE ANY EMPLOYMENT AFTER YOUR DISABILITY DATE.

a. NAME OF EMPLOYER	b. ADDRESS OF EMPLOYER INCLUDE CITY, STATE, ZIP CODE	c. TYPE OF WORK OR JOB TITLE	d. PERIOD OF EMPLOYMENT				e. LOCAL # AT TIME OF EMPLOYMENT
			FROM		TO		
			MO.	YR.	MO.	YR.	
	ADDRESS						
	CITY, STATE & ZIP						
f. COMPANY FORMERLY OR LATER KNOWN AS							
g. COMPANY OUT OF BUSINESS? <input type="checkbox"/> YES <input type="checkbox"/> NO							
	ADDRESS						
	CITY, STATE & ZIP						
f. COMPANY FORMERLY OR LATER KNOWN AS							
g. COMPANY OUT OF BUSINESS? <input type="checkbox"/> YES <input type="checkbox"/> NO							
	ADDRESS						
	CITY, STATE & ZIP						
f. COMPANY FORMERLY OR LATER KNOWN AS							
g. COMPANY OUT OF BUSINESS? <input type="checkbox"/> YES <input type="checkbox"/> NO							
	ADDRESS						
	CITY, STATE & ZIP						
f. COMPANY FORMERLY OR LATER KNOWN AS							
g. COMPANY OUT OF BUSINESS? <input type="checkbox"/> YES <input type="checkbox"/> NO							
	ADDRESS						
	CITY, STATE & ZIP						
f. COMPANY FORMERLY OR LATER KNOWN AS							
g. COMPANY OUT OF BUSINESS? <input type="checkbox"/> YES <input type="checkbox"/> NO							
	ADDRESS						
	CITY, STATE & ZIP						
f. COMPANY FORMERLY OR LATER KNOWN AS							
g. COMPANY OUT OF BUSINESS? <input type="checkbox"/> YES <input type="checkbox"/> NO							
	ADDRESS						
	CITY, STATE & ZIP						
f. COMPANY FORMERLY OR LATER KNOWN AS							
g. COMPANY OUT OF BUSINESS? <input type="checkbox"/> YES <input type="checkbox"/> NO							

EMPLOYMENT HISTORY (CONTINUED)

a. NAME OF EMPLOYER	b. ADDRESS OF EMPLOYER INCLUDE CITY, STATE, ZIP CODE	c. TYPE OF WORK OR JOB TITLE	d. PERIOD OF EMPLOYMENT				e. LOCAL # AT TIME OF EMPLOYMENT
			FROM		TO		
			MO.	YR.	MO.	YR.	
	ADDRESS						
	CITY, STATE & ZIP						
f. COMPANY FORMERLY OR LATER KNOWN AS							
g. COMPANY OUT OF BUSINESS?	<input type="checkbox"/> YES <input type="checkbox"/> NO						
	ADDRESS						
	CITY, STATE & ZIP						
f. COMPANY FORMERLY OR LATER KNOWN AS							
g. COMPANY OUT OF BUSINESS?	<input type="checkbox"/> YES <input type="checkbox"/> NO						
	ADDRESS						
	CITY, STATE & ZIP						
f. COMPANY FORMERLY OR LATER KNOWN AS							
g. COMPANY OUT OF BUSINESS?	<input type="checkbox"/> YES <input type="checkbox"/> NO						
	ADDRESS						
	CITY, STATE & ZIP						
f. COMPANY FORMERLY OR LATER KNOWN AS							
g. COMPANY OUT OF BUSINESS?	<input type="checkbox"/> YES <input type="checkbox"/> NO						
	ADDRESS						
	CITY, STATE & ZIP						
f. COMPANY FORMERLY OR LATER KNOWN AS							
g. COMPANY OUT OF BUSINESS?	<input type="checkbox"/> YES <input type="checkbox"/> NO						
	ADDRESS						
	CITY, STATE & ZIP						
f. COMPANY FORMERLY OR LATER KNOWN AS							
g. COMPANY OUT OF BUSINESS?	<input type="checkbox"/> YES <input type="checkbox"/> NO						
	ADDRESS						
	CITY, STATE & ZIP						
f. COMPANY FORMERLY OR LATER KNOWN AS							
g. COMPANY OUT OF BUSINESS?	<input type="checkbox"/> YES <input type="checkbox"/> NO						

Please answer all the following questions:

h. Have you ever been self-employed? Yes  No

If yes, for what periods of time?

\_\_\_\_\_, 20\_\_\_\_ to \_\_\_\_\_, 20\_\_\_\_  
 (month) (year) (month) (year)  
 \_\_\_\_\_, 20\_\_\_\_ to \_\_\_\_\_, 20\_\_\_\_  
 (month) (year) (month) (year)

What did you do when you were self-employed and what was the name of the company?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

i. Did you ever work as a supervisor, manager, foreman or in any position where you had the authority to hire or fire or to recommend it?

Yes  No

If yes, fill in the following information:

<u>Position</u>	<u>Company Name</u>	<u>Period of Time</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

j. Did you ever own and/or operate your own equipment?

Yes  No

If yes, fill in the following information:

<u>Period of Time</u>	<u>Type and Number of Pieces of Equipment</u>	<u>Company Associated With</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

k. Have you ever had any type of ownership in any of the companies listed on your record of employment?

Yes  No

If yes, list the company name(s) and dates of ownership.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Section 6 - CONTINUOUS EMPLOYMENT**

Since January 31, 1955, was there any period of more than one year when you worked at any job other than in the teamster industry, or were not actively employed for any reason?

Yes  No

If yes,

<u>PERIOD OF TIME</u>	<u>REASON</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Section 7 - MILITARY RECORD**

RECORD OF U.S. MILITARY SERVICE		b. PERIOD OF SERVICE			
		FROM		TO	
a.	BRANCH OF SERVICE	MONTH	YEAR	MONTH	YEAR

**c. ATTACH DISCHARGE PAPERS**

**Section 8 - OTHER PENSION COVERAGE**

LIST COVERAGE UNDER ANY OTHER TEAMSTER PENSION FUND AND/OR COMPANY PENSION FUND		c. PERIOD OF MEMBERSHIP					
		FROM		TO			
a.	NAME OF FUND	b.	ADDRESS, CITY, STATE	MONTH	YEAR	MONTH	YEAR

**Section 9 - PHYSICIAN/PRACTITIONER INFORMATION**

LIST EVERY PHYSICIAN OR PRACTITIONER WHO ATTENDED OR PRESCRIBED DURING PRESENT AFFLICTION.

a.	NAME	b.	ADDRESS, CITY, STATE & ZIP CODE	c. FROM		TO	
				MONTH	YEAR	MONTH	YEAR

**OATH AND SIGNATURE**

I authorize any hospital that I have been confined in or any physician who has treated me or is now treating me to give Central States, Southwest and Southwest Areas Pension Fund any information. I agree to notify the Fund immediately of any employment. The information I have given in this application is true and correct to the best of my knowledge.

\_\_\_\_\_  
APPLICANT SIGNATURE

\_\_\_\_\_  
DATE



**AUTHORIZATION TO THE SOCIAL SECURITY ADMINISTRATION  
TO LIST WAGES AND EMPLOYERS**

The portion of this form indicating the period for which employers and wages are to be listed **MUST BE LEFT BLANK**. This form must be signed by the account number holder. If he is incapable of a written signature but can "Make his Mark," the Mark must be witnessed by two impartial parties. If the account number holder is mentally or physically incompetent, the form may be signed by his guardian or conservator.

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**AUTHORIZATION TO OBTAIN EARNINGS DATA FROM THE  
SOCIAL SECURITY ADMINISTRATION**

JOB NO. 8287

NAME \_\_\_\_\_  
PLEASE PRINT

SOCIAL SECURITY NO. \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

**Social Security Administration  
Box 57  
Baltimore, Maryland 21203**

Please furnish the Central States, Southeast and Southwest Areas Pension Fund, PO Box 5109 Des Plaines IL 60017-5109, an itemized statement of all quarterly and annual amounts of wages reported by my record for the periods specified by that organization, and the identification numbers, names and addresses of the reporting employers.

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**Date Signed**

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**Signature of Social Security Number Holder**

**TO BE FILLED IN BY PENSION FUND REPRESENTATIVE**

SOCIAL SECURITY ADMINISTRATION:

Please furnish the above information for the period \_\_\_\_\_ through \_\_\_\_\_ . This information is to be used only to determine initial eligibility for benefits.

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Date sent

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Countersignature of Pension Fund Representative

## ATTENDING PHYSICIAN'S STATEMENT REGARDING TOTAL DISABILITY BENEFITS

By giving full and complete answers, the attending physician will assist the Fund in passing promptly on the claim. This statement to be furnished without expense to the Fund.

FULL NAME OF CLAIMANT

WHERE IS CLAIMANT NOW LOCATED? (If an inmate of a hospital or other institution, give name and address.)

HOW LONG HAVE YOU BEEN CLAIMANT'S MEDICAL ADVISOR?

WHEN DID CLAIMANT'S HEALTH FIRST BECOME AFFECTED?

MONTH

DAY

YEAR

GIVE SYMPTOMS, DIAGNOSIS AND PROGNOSIS OF CLAIMANT'S DISABILITY

IS CLAIMANT WHOLLY DISABLED AND PREVENTED FROM ENGAGING IN ANY BUSINESS OR OCCUPATION WHATSOEVER?

IF HE IS, FROM WHAT DATE, TO YOUR KNOWLEDGE, HAS HE BEEN SO PREVENTED?

MONTH

DAY

YEAR

DATE OF YOUR FIRST VISIT OR OR PRESCRIPTION IN PRESENT AFFLICTION?

MONTH

DAY

YEAR

IS CLAIMANT NOW CONFINED TO HIS BED OR HOUSE? STATE WHICH AND FROM WHAT DATE.

BARRING ANY UNEXPECTED IMPROVEMENT IN THE CLAIMANT'S CONDITION, DO YOU THINK HE WILL EVER BE ABLE TO DO ANY KIND OF WORK?

SIGNATURE OF PHYSICIAN

DATE

ADDRESS

CITY

STATE

SIGNATURE OF PHYSICIAN

DATE

ADDRESS

CITY

STATE

## CHECK LIST

Have you enclosed:

Completed and Signed Application .....

Copies of:

- Birth Certificates or Proof of age for:
  - Yourself .....
  - Spouse .....
  - Dependent Children .....
- Marriage Certificate .....
- Divorce Papers .....
- Military Service Records .....
- Entire Social Insurance Award .....
- Copy of your recent Social Security Disability Check if your Award is over one year old .....

Completed Forms:

- Employment Affidavit .....
- Authorization to the Social Security Administration .....
- Attending Physician's Statement .....

Have you made copies of your completed application for:

- Yourself .....
- Your Local Union .....