Southwestern Illinois Laborers' Annuity Fund

TOTAL AND PERMANENT DISABILITY ANNUITY QUESTIONNAIRE

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: _____ Age: _____

Date First Treated: _____ Date Last Treated: _____

1. Diagnosis (Please provide ICDA codes if available)

   _____

   _____

2. Frequency of care? Weekly □ Monthly □ Annual □ Other _____

3. Based on medical evidence, do you believe this Patient is totally and permanently disabled and prevented from performing duties of his/her occupation? Yes□ No□

   Comments: _____

   _____

4. Date disability commenced? _____ Has disability been continuous? Yes □ No □

5. Is it your opinion that the disability will likely continue for the participant's lifetime or for an indefinite duration? Yes□ No□

6. REMARKS: _____

   _____

   _____

   _____

   _____

Date Physician's Name (Print) Physician's Signature Degree Telephone No.

_____

Street Address City/Town State/Providence Zip Code

THIS FORM IS NOT VALID WITHOUT THE PHYSICIAN'S *WRITTEN* SIGNATURE