OPERATING ENGINEERS TRUST FUNDS

I.U.O.E. LOCAL 12 HEALTH & WELFARE / PENSION / VACATION / DCP

100 CORSON STREET, SUITE 100 • PASADENA, CALIFORNIA 91103 • (866) 400-5200
P.O. BOX 7063, PASADENA, CALIFORNIA 91109
TTY: (626) 356-3582 WEBSITE: www.oefi.org

Application For One Year Disability Extension Of Eligibility

Participant's Information			
Social Security Number/OE ID	Last Name	First Name	Middle Initial

Address Information		
Street Address		
City	State	ZIP Code

Home Phone Number	Mobile Phone Number	Email Address
( )	( )	

Certificate Of Disability - To be completed and signed by the participant		
Date(s) you were unable to work: _____/_____/_____ to _____/_____/_____	Are you still disabled? ☐ Yes ☐ No	What date do you expect to return to work? _____/_____/_____
Is this disability in any way related to your employment or occupation? ☐ Yes ☐ No	Please describe the medical condition:	

I hereby certify that the forgoing statements, including any accompanying statements, are true, correct and complete to the best of my knowledge and hereby further authorize my attending physician, practitioner or hospital in which confinement took place to furnish and disclose all facts concerning my physical condition that are within their knowledge.

Signature (required)	
X	Date: _____/_____/_____

Certificate Of Disability - To be completed and signed by the doctor	
Patient's Name	Patient's Date of Birth _____/_____/_____
ICD-10 Code(s):	Date of patient's first treatment for this condition: _____/_____/_____
Physician Name	Physician Tax ID #
I certify that this patient was unable to perform his/her regular and customary work for the period: _____/_____/_____ to _____/_____/_____	Phone Number ( )

Mailing Address	City	State	ZIP Code

Attending Physician's Signature	
X	Date _____/_____/_____

Return to: Operating Engineers Health and Welfare Fund, PO Box 7067, Pasadena, CA 91109
FAX (626) 356-3566 or email: HWdisability@oefi.org