The Cement Masons – Employers Health, Welfare & Vacation Trust offers Disability Waivers to ill or injured members. Disability Waivers are provided by the Trust to extend coverage to disabled employees without using their Reserve Account and without using contributions from a contributing employer. Up to six Disability Waivers are provided per disability. The number of Disability Waivers applied is determined by the length of your doctor certified disability. In no case will more than six be applied per disability.

To be eligible for a Disability Waiver, a physician needs to certify your disability and the disability must have occurred while your coverage was in effect under the Plan.

If you wish to apply for the Disability Waivers, please complete the upper portion of the Disability Waiver application. You will then need to have your physician complete the lower portion of the form. Once completed, return to our office at 9848 E . Burnside, Portland, Oregon 97216. If you have any questions on this benefit, please contact the Trust Office at 503-254-4022 or toll free at 1-800-591-8326.

Cement Masons H&W Trust Fund
9848 E BURNSIDE
PORTLAND OR 97216
(503) 254-4022 (503) 254-4119 FAX
TOLL FREE 1 800 591-8326

DISABILITY WAIVER APPLICATION

There are a total of six (6) Disability Waivers available per disability. You must be covered the month the disability occurred to be eligible. Please complete the "Employee" section and have your physician complete the "Physician" section. Please promptly return to the address at the left.

Employee Information

Soc. Sec.# _____

Name: _____

Check One:

This is the first time I'm submitting this form ☐

I am submitting an **update** on my disability ☐

Date last worked_____

Have you returned to work_____
If yes, on what date_____

I understand that there are six Disability Waivers available per disability and I authorize the Trust Office to Apply all applicable waivers based on the information supplied by my physician.

_____
Signature of Participant Date

Please have your **physician** complete the bottom portion. Please return to the Trust Office at the above address.

Physician Information

I certify I attended_____ Age_____

Is disabled due to (circle one): Accident/Injury or Illness

If ILLNESS: Diagnosis:_____

Date of first medical treatment:_____

Nature of surgical or obstetrical procedure, if any (describe fully):_____

Where performed:_____ Date:_____

The patient has been continuously disabled (unable to work) from:_____ **Through:**_____

If released to "light duty" what is date released and restrictions:_____

When should patient be able to return to un-restricted work (*please estimate if exact date unknown*):_____

Remarks:_____

_____

Signature of attending physician:_____ Date:_____

Address:_____

_____ **Phone:**_____