trust fund office

# local union 831

employer health trust fund

employer pension plan

## MEDICAL PROOF OF DISABILITY

To: Local Union 831-Employer Health Trust Fund Date: _____
P.O. Box 5528
El Monte, CA 91734

I, _____ SOCIAL SECURITY # _____ do hereby certify that as a result of a non-work related/work related injury, I was physically unable to work for the period of _____ to _____.

Therefore, I request that my coverage be extended by the Trust Fund.

_____ _____
Signature Local Union #

_____
Mailing Address City State Zip Code

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**TO BE COMPLETED BY ATTENDING PHYSICIAN**

The employee named above is unable to work from _____ to _____.
Date Date

Due to _____
Diagnosis (ICD9 code, if available)

He should be physically able to work by _____.

_____ _____
Physician's Name Physician's Address City & Zip Code

_____ _____
Physician's Signature Telephone #

**IS THIS DISABILITY OCCUPATIONAL? ___ YES ___ NO**
(MUST BE COMPLETED)

***P.O. Box 5528, El Monte, California 91734***
Toll Free: 1.877.572.7005 Phone: 626.279.3080 Fax: 626.279.3055