

# **MILLMEN PENSION FUND MEDICAL EXAMINATION FORM**

**PLEASE HAVE YOUR PHYSICIAN READ THE FOLLOWING  
EXCERPTS FROM THE PENSION PLAN DOCUMENT CAREFULLY  
BEFORE COMPLETING THIS FORM.**

## **Section 1.14 of the Millmen Plan Document Defines the Term “DISABLED”**

%Disabled+means that a Participant is unable to engage in any %substantial gainful activity+by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

## **Section 3.8(c) of the Millmen Plan Document States:**

A Disability Pensioner shall report all and any earnings from any employment or gainful pursuit to the Trustees, in writing, within fifteen (15) days after the end of any month in which he/she has such earnings so that such Disability Pension can be terminated. **In the event such monthly earnings resulted from employment or gainful pursuit not in Prohibited Employment and not in excess of the applicable monthly “substantial gainful activity” amount as published by the Social Security Administration, from time to time, the Disability Pension shall not be terminated for that month.** If a Disability Pensioner fails to make timely reports as required in this subsection c., he/she shall be disqualified for Disability Benefits for those months in which he/she had any earnings from employment or other gainful pursuit regardless of the exception in the preceding sentence. The Trustees have the discretion to determine whether there were extenuating circumstances which prevented the Disability Pensioner from making such timely reports.+

***For your information, the 2010 Social Security Administration’s “substantial gainful activity” limit is \$1,000.00 per month. Employment that would lead to earnings greater than this amount is considered to be “substantial.”***

# MEDICAL EXAMINATION REPORT (MILLMEN FUND)

Participant Name \_\_\_\_\_ Participant SS# OR UID# \_\_\_\_\_ Participant Date of Birth \_\_\_\_\_

Participant Address \_\_\_\_\_  
Number Street City State Zip Code

## **ALL OF THE FOLLOWING INFORMATION MUST BE COMPLETED BY THE PHYSICIAN**

**DIAGNOSIS** INCLUDING SUBJECTIVE SYMPTOMS, OBJECTIVE CLINICAL FINDINGS, OBJECTIVE DIAGNOSTIC STUDIES AND RESULTS, COMPLICATIONS, AND THE BASIS FOR YOUR ULTIMATE FINDING OF TOTAL DISABILITY (CONTINUE ON BOTTOM OF REVERSE SIDE IF MORE SPACE IS NEEDED)

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

The above named individual was most recently examined on \_\_\_\_\_.

ICD diagnostic code: \_\_\_\_\_

This disability commenced on or about: \_\_\_\_\_ (MONTH/DAY/YEAR)

Medical treatment (is) \_\_\_\_\_ (is not) \_\_\_\_\_ required at the present time.

Re-examination is recommended on or about \_\_\_\_\_.

**I certify that I have reviewed the Pension Plan disability information that appears on the reverse side of this form. After reviewing this information, I hereby certify that:**

### **IMPORTANT -- PHYSICIAN MUST INITIAL WHICHEVER APPLIES**

\_\_\_\_\_ I am of the opinion that this individual is totally and completely disabled for Substantial Gainful Employment due to a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or **can be expected to last for a continuous period of not less than 12 months.**

\_\_\_\_\_ I am of the opinion that this individual is **NOT** totally and completely disabled for Substantial Gainful Employment and is able to engage in employment as follows:

Physician Printed Name \_\_\_\_\_ (must be LEGIBLE) Physician Signature \_\_\_\_\_ Date Completed by Physician \_\_\_\_\_

Address \_\_\_\_\_  
Number Street City State Zip

Telephone \_\_\_\_\_ (Area Code) Number Physician Federal Tax I.D. # \_\_\_\_\_

Physician License # \_\_\_\_\_ License Issued by State of \_\_\_\_\_