HAWAII LABORERS TRUST FUNDS

1440 KAPIOLANI BLVD., SUITE 800 - HONOLULU, HAWAII 96814 – Fax (808) 441-8750
PHONE (808) 441-8600 - NEIGHBOR ISLANDS DIAL DIRECT 1 (888) 520-8078

ANNUITY • HEALTH & WELFARE • LECET • PENSION • TRAINING • VACATION

DISABILITY CERTIFICATION

Member's Name:	
Member's Social Security Number:	
Address: (Street, City, St & Zip Code)	
Phone Number:	

MEMBER'S STATEMENT
(Incomplete statements will be sent back and may delay benefits)

My present/last employer is:	
Date my disability commenced:	
I was working for my 'present/last employer' on the date my disability commenced?	**YES or NO**
If ***NO***, please provide date employment terminated:	
I am currently collecting unemployment? (circle one)	**YES or NO**
If ***YES***, please provide date unemployment benefits began:	
My disability was caused by employment? (circle one)	**YES or NO**
If circled 'Yes', please provide the following:	
Name of Workmen's Compensation Carrier:	
Phone Number:	

I certify under penalty of perjury that all of the above statements are true and correct to the best of my knowledge. I further understand that a false statement may disqualify me for Disability Credits and that the Trustees shall have the right to recover any credits/payments made because of a false statement.

Member's Signature: X____ **Date:** ____________________

PHYSICIAN'S STATEMENT

Injury/disability date:			
Date unable to work:			
Nature of injury: ***(Do not leave blank or unknown)***			
Date of patient's last visit with you:			
Is patient still disabled and unable to work? (circle one)	**YES**	**NO**	
RELEASED to return to covered employment: *(check one)*	☐ **FULL TIME** **Date:**	☐ **LIGHT DUTY** **Date:**	☐ **PENDING** **(Note details)**
Physician's Phone Number:			
Physician's Name (please print)			
Physician's Signature: ***(Rubber stamp required)***		Date:	

IMPORTANT NOTE TO MEMBER:

In the event that you become disabled, you must notify the Trust Fund Office in writing immediately or no later than 45 days after the initial disability commences to qualify for disability credits. **You must send in an updated disability certificate by the 30th of each month until you return back to covered employment.** If the Trust Fund Office does not receive this form timely, you may disqualify yourself from continuous Health & Welfare Coverage.

Office Use Only	**Wk Mo**		**Wk Hrs**		**Hrs App**		**Eli. Mo**	