PIPE TRADES INDUSTRY HEALTH AND WELFARE PLAN
P.O. BOX 3040 TERRE HAUTE, INDIANA 47803
812-877-2581

PROOF OF INCAPACITATED CHILD

Part 1

TO BE COMPLETED BY EMPLOYEE LOCAL UNION # _____

_____ _____
Member's name SSN#

_____ _____
Address Telephone #

_____
Address 2

_____ _____
Child's name Date of birth

Male _____ Female _____ Status: Married _____
Single _____

Is child permanently residing in your household? Yes ____ No _____

If "NO", why not? _____
_____
_____

Is child covered under any other hospital or medical coverage? Yes_____ No _____

If "Yes", give names of insurance company and policy #: _____
_____

Describe Disability: _____
_____
_____
_____

I certify that the above information is true and correct. I hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to furnish Pipe Trades Industry Health and Welfare Plan with full information regarding treatment rendered (including copies of their records). A copy or photocopy of this authorization shall be considered as effective and valid as the original. Also, I hereby understand that Pipe Trades Industry Health and Welfare Plan may request proof of the incapacitation of the above-named child as often as it may reasonably require and that Pipe Trades Industry Health and Welfare Plan is in no way waiving its right to decline to continue the coverage if in its opinion the incapacitation does not fulfill the requirements of the Plan.

EMPLOYEE'S SIGNATURE _____ Date _____

Part 2

TO BE COMPLETED BY ATTENDING PHYSICIAN
(Note:) Any fee for the completion of this form is the responsibility of the employee.

1. Is child now incapable of self-support because of disability? Yes _____ No _____
2. Has such disability existed continuously since before child attained the age of twenty-one? Yes _____ No___
3. Nature of disability (please give as much detail as possible).____

Prognosis (estimate months or years)_____

Physician's name _____ Degree _____

Address _____

Phone _____

PHYSICIAN'S SIGNATURE _____ Date _____