



CHRISTIAN SCHOOL PENSION PLAN AND TRUST FUND

3350 East Paris Avenue SE
Grand Rapids, MI 49512-3054

CERTIFICATION OF DISABILITY FORM

PART I - TO BE COMPLETED BY EMPLOYEE

Name _____ Soc.Sec.No. _____
Height _____ Weight _____ lbs Employer _____

I have made application for temporary disability benefits under Section 6.6 of the Plan. In support of the application, I hereby request my attending physician, to release to the Trustees of the Christian School Pension Plan or to UNUM Life Insurance Company any pertinent information in my file and/or records, including the information below.

Employee's Signature _____ Date _____

PART II - TO BE COMPLETED BY ATTENDING PHYSICIAN

Physician's Name _____ Telephone No. _____
Address _____ Facsimile No. _____

The above named participant in the Christian School Pension Plan has made application for temporary disability benefits. In order to process the application, please furnish the following information:

1. Nature of disability: _____ Primary Diagnosis ICD-9 _____
2. Has this patient ever had the same or similar condition: No Yes If Yes what year(s) _____
3. Describe: _____
4. Has the patient undergone surgery? No Yes If Yes provide date, procedure and result: _____
5. If No, do you expect surgery to be performed in the future? No Yes If Yes, provide date, procedure and result: _____
6. If disability is due to pregnancy, expected delivery date: _____
7. Treatment: _____(continue on reverse)
8. Date(s) you were consulted regarding this disability: First Date: _____
Most Recent Date: _____ Next appointment date: _____
9. Date work had to be discontinued due to this disability: _____
10. Expected length of this disability: _____
11. Date participant is expected to be able to return to work:
Part time (less than 50% of regular schedule): _____ 20_____
Part time (50% or more of regular schedule): _____ 20_____
Full time (regular schedule): _____ 20_____
12. Is condition due to injury/sickness arising out of patient's employment? No Yes
13. Comments: _____(continue on reverse)

Physician's Signature _____ Date: _____

7. Description of Treatment:

13. Comments:
