UFCW CONSOLIDATED
PENSION FUND
1740 Phoenix Parkway
ATLANTA, GA 30349

DISABILITY CERTIFICATE

TO BE COMPLETED BY MEDICAL DOCTOR

Patient's Name _____ S.S. No. _____

Address _____

This is to certify that I have examined the patient above on _____ 20_____

"Disability" under the Pension Plan is defined as a physical or mental condition which totally and permanently prevents an employee from engaging in his last regular position of employment.

As a result of my examination, it is my considered opinion that this patient (check one):

- ☐ IS totally and permanently disabled pursuant to the Plan definition,
- ☐ IS NOT totally and permanently disabled pursuant to the Plan definition,

AND that the most reasonable expectation is that (check one):

- ☐ He/She should in time recover sufficiently to return to his/her last regular position of employment.
- ☐ His/Her condition will continue for a long and indefinite period or result in death.

In my opinion, this patient's disability commenced as of _____, 20_____
(PLEASE NOTE, this date must coincide with the date the patient last worked with his/her participating employer.)

My opinion is based on the following diagnosis and considerations:

_____

_____

To the best of your knowledge, has the patient's condition resulted from (enter YES or No or Unknown):

- _____ Chronic Alcoholism?
- _____ Addiction to Narcotics?
- _____ Injury suffered while engaged in a criminal act or enterprise?
- _____ An intentionally self-inflicted injury?

If you believe examination by a specialist would be advisable in order to establish conclusively the patient's disability status, please indicate the type of specialist that you would recommend:

_____

Remarks:

_____

_____

THIS SECTION MUST BE COMPLETED LEGIBLY AND IN ITS ENTIRETY BY A MEDICAL DOCTOR:

Doctor's Name: _____

Address: _____

City, State & Zip _____ Office Phone Number:_____

Doctor's Signature _____ Date _____