LABORERS' PENSION FUND OF WESTERN CANADA

Registration #0371237

Medical Report for Disability Pension

Please print and be sure to sign and date this report. Please provide details in layman's terms whenever possible. Incomplete or illegible information may result in the rejection of the applicant's claim. A further independent medical examination and/or annual review may be required.

Mail the completed report and supporting medical documentation which may be relevant to the fund office at the address at the end of this form.

Any fees applicable for the completion of this form are the responsibility of the applicant.

Member Information		
Name (Last)	(First)	Social Insurance Number

Physician Statements					
The member is requesting, or is receiving, a disability pension from the Laborers Pension Fund of Western Canada. To be eligible, the member must be completely unable, due to physical or mental impairment, to engage in any and every gainful occupation for which he/she is reasonably fitted by education, training or experience, and such disability must be permanent and continuous for the remainder of his/her life.					
Is the member totally and permanently disabled, as defined above?				Yes	No
If NO, date the member was no longer disabled.	Month	Day	Year		
If YES, date the member became totally disabled.	Month	Day	Year		
Is the member's disability terminal, with a life expectancy of less than 2 years?				Yes	No
Date of first visit	Month	Day	Year		
Date of last visit	Month	Day	Year		
Does the member have regular visits?				Yes	No
If you were not the physician in attendance at the onset of disability, please advise how the date of disability was determined.					
Diagnosis					

COMPLETE REVERSE SIDE AS WELL

Please explain how the medical condition prevents the member from being able to work.
Describe any medication/treatment programs already provided and the results obtained.
Outline if any other treatment options are available (i.e. surgery, exercise, physiotherapy, medication, diet) which may alleviate this condition.
Give particulars of all other medical practitioners consulted or to whom the applicant has been referred (i.e. other physicians, specialist, or therapists), the date of consultation, and the results obtained.

Certification

I, the undersigned, a medical doctor licensed to practice under the laws of the province of _____, certify the above information to be true based on my knowledge of the member.

Signature of Physician	Date
Name of Physician (please print)	Address
Telephone	City, Province, Postal Code

I hereby authorize my physician to release any relevant medical information to the Laborers' Pension Fund of Western Canada.

Signature of Member	Date

You will be notified in writing if any additional information is required.

Please return this form, with your original signature by mail to:

Ellement Consulting Group
10154 108 Street NW
Edmonton AB T5J 1L3

Phone: 780-453-2303 Toll Free: 800-661-7369 Email: laborers@ellement.ca