



HARRISON TRUST
A Family Health Plan

DISABILITY APPLICATION

This form must be completed and mailed to the Board of Trustees for the Monthly Deduction Waiver explained on Pages 5 and 6 of your Health & Welfare Booklet. Return completed form to: 1220 SW Morrison, Suite 300
Portland, Oregon 97205

This form must be forwarded to the Trustees within 45 days of the date disability commenced.

**** THIS SECTION TO BE COMPLETED BY THE EMPLOYEE ****

Employee Name _____ Address _____

Date Employee last worked: _____, 20____. Social Security #: _____

Has Employee returned to work? _____ If so, on what date? _____

Employee Signature: _____ Phone: _____

CERTIFICATE OF ATTENDING PHYSICIAN

I certify I attended: _____ Age: _____

(Is disability due to an accident? _____ Nature of Injury: _____

INJURY (Brief History: _____

(Symptoms: _____

ILLNESS (Objective Findings: _____

(Diagnosis: _____

Date of First Medical Treatment: _____

Nature of surgical or obstetrical procedure: _____

Where performed: _____ Date: _____

If in Hospital, In-patient: _____ Out-patient: _____

The patient has been continuously disabled (unable to work) from: _____ to _____

If still disabled, when should patient be able to return to work? _____

Remarks: _____

Date: _____ Signed: _____

Address: _____ Phone: _____

Local Union Approval: _____

Local Number

Signature of Business Agent