

**MEBA PENSION TRUST  
1007 EASTERN AVENUE  
BALTIMORE, MD 21202-4345  
(800) 811-MEBA**

**PROOF OF TOTAL AND PERMANENT DISABILITY**

This form should be completed only if you are applying for a Disability Pension. Be advised that Disability Pensions are subject to an annual earned income limitation of \$36,000.

\_\_\_\_\_  
NAME

\_\_\_\_\_  
SOCIAL SECURITY NUMBER

**PART A. TO BE COMPLETED BY CLAIMANT (complete questions 1 through 8 and ask your doctor to complete PART B – Attending Physician’s Section)**

1. Are you presently employed in any capacity?  YES  NO

If yes, in what capacity? \_\_\_\_\_

If no, when did you cease employment? \_\_\_\_\_

2. What was the last date you worked in the Maritime Industry? \_\_\_\_\_ (Date)

3. On what date do you feel you can resume any type of work? \_\_\_\_\_ (Date)

4. Explain the nature of your disability. \_\_\_\_\_  
\_\_\_\_\_

5. When did this disability occur? \_\_\_\_\_ (Date)

6. Were you able to work for any period after the onset of the disability?  YES  NO

7. Have you applied for or received a Social Security Disability Award?  YES  NO

If you applied but have not yet received your award certificate, give date of application. \_\_\_\_\_ (Date)

8. If you have had an examination at a MEBA Diagnostic Center, indicate the date and location of your last examination and complete the attached authorization for release of health information.

DATE OF LATEST DIAGNOSTIC  
CENTER EXAMINATION:

DIAGNOSTIC CENTER LOCATION  
AT WHICH YOU WERE EXAMINED:

\_\_\_\_\_  
Month

\_\_\_\_\_  
Year

\_\_\_\_\_  
City

\_\_\_\_\_  
State

**PART B. TO BE COMPLETED BY ATTENDING PHYSICIAN (complete questions 9 through 23 and return this form directly to the MEBA Pension Trust at 1007 Eastern Avenue, Baltimore, MD 21202)**

9. In your medical opinion, will the patient be able to return to his current employment in the Maritime Industry?  YES  NO If yes, when? \_\_\_\_\_ (Date)
10. In your medical opinion, will the patient be able to be gainfully employed in any other type of employment?  YES  NO If yes, when? \_\_\_\_\_ (Date)
11. Please indicate the date on which the patient became permanently and totally disabled. \_\_\_\_\_ (Date)
12. Please indicate the first date on which you began treatment of this patient for this disability. \_\_\_\_\_ (Date)
13. Has this disability been continuous?  YES  NO
14. In what way is this patient disabled? Please describe. \_\_\_\_\_  
\_\_\_\_\_
15. What is your diagnosis of this disability? \_\_\_\_\_
16. Is treatment for the disability currently being provided?  YES  NO  
If yes, describe the treatment: \_\_\_\_\_  
\_\_\_\_\_
17. What is the patient's response to the treatment? \_\_\_\_\_  
\_\_\_\_\_
18. Was the patient confined to a hospital during any period of this disability?  YES  NO  
If yes, for how long? \_\_\_\_\_ Date(s) of hospitalization \_\_\_\_\_ (Date(s))
19. Is the patient confined to a bed?  YES  NO  
Is the patient in any way confined indoors?  YES  NO  
If yes, please describe the circumstances: \_\_\_\_\_  
\_\_\_\_\_
20. Did the patient have surgery?  YES  NO  
If yes, on what date: \_\_\_\_\_ (Date) Please describe surgery: \_\_\_\_\_  
\_\_\_\_\_
21. Is the patient mentally capable of transacting personal affairs, such as endorsing checks with the realization of the nature and consequences of his or her acts?  YES  NO
22. Remarks: \_\_\_\_\_  
\_\_\_\_\_
23. Please respond below if this disability is due to a cardiac condition:  
a. Functional Capacity (American Heart Association)  
 Class 1 (No Limitation)  Class 2 (Slight Limitation)  
 Class 3 (Marked Limitation)  Class 4 (Complete Limitation)  
b. Blood Pressure Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_
- Physician's Signature: \_\_\_\_\_ Dated: \_\_\_\_\_  
Address: \_\_\_\_\_  
Degree \_\_\_\_\_ Year \_\_\_\_\_ State License #: \_\_\_\_\_  
Employer ID #: \_\_\_\_\_