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:

_____ _____
Month Year

DIAGNOSTIC CENTER LOCATION AT WHICH YOU WERE EXAMINED:

_____ _____
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 anyway 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 #: _____