



Airconditioning And Refrigeration Industry Joint Trust Funds

3500 WEST ORANGEWOOD AVENUE, ORANGE, CALIFORNIA 92868 • PHONE: (714) 917-6100 • FAX: (714) 917-6065

DISABILITY BENEFITS APPLICATION

PARTICIPANT'S STATEMENT OF DISABILITY

PARTICIPANT'S NAME		SOCIAL SECURITY NO.
ADDRESS	NUMBER AND STREET	DATE OF BIRTH ()
CITY, STATE, ZIP CODE		TELEPHONE NO.
EMPLOYER'S NAME	STREET ADDRESS	CITY, STATE, ZIP CODE

IF DISABILITY WAS CAUSED BY ACCIDENT, COMPLETE THE FOLLOWING:

DATE OF ACCIDENT	TIME OF DAY	LOCATION
DESCRIBE ACCIDENT BRIEFLY		

PARTICIPANT'S SIGNATURE

DATE

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

NATURE OF ILLNESS OR INJURY:		
PATIENT CONTINUOUS DISABLED AND UNABLE TO WORK:	FROM (DATE)	THROUGH (DATE)
PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:	(DATE)	
ADDITIONAL REMARKS:		
PRINT PHYSICIAN'S NAME	TELEPHONE NO.	(DATE)
STREET ADDRESS	CITY,	STATE, ZIP CODE
PRACTITIONER SSN OR EMPLOYER ID#	PHYSICIAN'S SIGNATURE	