NATIONAL IAM
BENEFIT TRUST FUND

DISABLED DEPENDENT CERTIFICATION

Employee Name: _____

Employee SSN: _____

Dependent Name: _____

Relationship: _____ **Date of Birth:** _____

I declare under penalty of perjury that the above noted dependent:

(Please check only one of the following boxes)

☐ **Is my qualified dependent who is incapable of self-sustaining employment as the result of mental or physical handicap, and who remains chiefly dependent upon me for financial support.** (Attach attending physician certification.)

☐ **Was formerly my qualified dependent, but is no longer chiefly dependent on me for financial support as of:**

_____
(Status change date)

I understand that the above certification will be used as a basis for determining dependent eligibility under the Plan, and that it is my obligation to advise the Plan of any change in dependency status.

I promise to notify the Fund Office immediately if this dependent becomes capable of self-sustaining employment or if this dependent ceases to be chiefly dependent upon me for financial support.

SIGNED: _____
(Covered Employee)

DATE: _____

99 M Street SE, Suite 600, Washington, DC 20003-3799
www.iambtf.org 1-800-457-3481

NATIONAL IAM
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PHYSICIAN CERTIFICATION OF DISABILITY

Patient Name: _____

Employee Name: _____

I certify that the above patient is incapable of self-sustaining employment due to the following physical and/or mental handicap:

_____
(Diagnosis and concurrent conditions)

_____
(Additional comments or clarification)

The above patient has been totally disabled since: _____
(Date)

He/she is expected to remain totally disabled until: _____
(Date)

Last evaluation: _____ **Next evaluation:** _____
(Date) (Date)

PLEASE ATTACH A COPY OF THE PATIENT'S MOST RECENT MEDICAL EVALUATION IN CONNECTION WITH THE DISABLING CONDITION.

Physician Signature: _____
(Name and degree)

Date Signed: _____

Physician Name: _____
(Please Print Full Name)

Physician Address: _____
(Street Address)

_____
(City, State, and Zip)

Telephone Number: _____