HANDICAPPED CHILD DISABILITY CERTIFICATION (0P)

I. Employee's Statement

NAME OF CHILD	DATE OF BIRTH

I certify that the above-named child is solely dependent upon me for support and is not married. I hereby request that (he) (she) be continued as a covered dependent under the Health and Welfare Plan.

NAME OF EMPLOYEE	SOCIAL SECURITY NO.

STREET ADDRESS	CITY	STATE	ZIP

SIGNATURE OF EMPLOYEE	DATE

II. Patient's Authorization for Release of Medical Information

The undersigned patient hereby authorizes any provider of health care, physician or other practitioner, hospital, insurer, self-insurer, consumer reporting agency, employer, union or other labor organization or group policy holder to furnish and disclose to the Cement Masons Health and Welfare Trust Fund for Northern California and Cement Masons Pension Trust Fund for Northern California, or any person or entity representing such Fund, all records or other information in their control or within their knowledge concerning his medical history, physical or mental condition, or any consultation, prognosis, diagnosis or treatment, for use solely in the processing of the within claim, including any procedure for the coordination of benefits or for reciprocity. The undersigned also hereby authorizes such Fund or any person or entity representing such Fund, to acquire, possess, utilize and disclose such information for such purpose, including the disclosure thereof to any provider of health care, insurer, self-insurer, hospital, health care service plan or employer, union, or other labor organization, or any person or entity representing any of the foregoing. This authorization shall remain valid until the claim has been fully processed, including any procedures for review or investigation of the claim after payment. The undersigned understands that he has the right to receive a true copy of this signed authorization upon demand. This authorization is intended to be valid authorization pursuant to California Civil Code Section 56.10 and shall be construed to give effect to this intention. A photocopy of this authorization shall be as valid as the original.

PATIENT'S SIGNATURE (claim cannot be processed unless signed personally)	DATE

III. Physician's Certification

NAME OF DISABLED CHILD	DATE OF BIRTH

This is to certify that I have examined the above-named patient and find (him)(her) to be incapable of self-support because of disability which began before attainment of age 19.

The following information is offered in support of this certification:

1. NATURE OF DISABILITY _____

2. DISABILITY HAS BEEN CONTINUOUS FROM _____

3. IS THIS DISABILITY PERMANENT AND EXPECTED TO REMAIN CONTINUOUS FOR THE REMAINDER OF THE PATIENT'S LIFETIME? ☐ YES ☐ NO

4. IF THE ANSWER TO QUESTION NUMBER 3 IS "NO", DO YOU EXPECT THE PATIENT TO HAVE RECOVERED SUFFICIENTLY TO BE CAPABLE OF SELF-SUPPORT AFTER:
   ☐ ONE YEAR ☐ TWO YEARS ☐ MORE THAN TWO YEARS

PHYSICIAN'S NAME (PLEASE PRINT)	
PHYSICIAN'S SIGNATURE	DATE

CM 2049 (Rev. 6/2017)

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