REQUEST FOR PENSION INFORMATION

APPLICANT: Please complete all blanks in the **top portion** of the form.

APPLICANT: ________________________________
Signature

Name ________________________________

Address: ________________________________

____

Birth Date: ______/ ______/ ______

Social Security #: _________ - ______ - _________

Union Local #: __________

COMPANY PENSION PLAN OR
LONG TERM **DISABILITY** PROVIDER:

____

Union Name: ________________________________

Administered by: ____________________

Address: ________________________________

Address: ________________________________

____

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****************************APPLICANT STOP HERE******************************

PENSION REPRESENTATIVE: The State of California, Division of Workers' Compensation, Subsequent Injuries Fund requires information regarding my pension. Please complete the verification below for its confidential use.

1. Commencement Date of **DISABILITY** pension or Long Term **Disability**: ______/ ______/ ______
2. Medical conditions **(disability)** considered at the time of pension/LTD:

____

3. The amount of the initial monthly **disability** benefit, and the effective date and amount of any changes:

____

4. If the member were NOT **disabled**, would the member be eligible for regular retirement benefits now, in the past, or in the future?
No ( ) Yes ( ) If "yes", what would the first date of regular retirement be and what monthly benefit amount?

____

5. Will this member have a right to convert to REGULAR retirement at a later date?
No ( ) Yes ( ) If "yes" what would be the first date and what monthly benefit amount?

____

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COMPLETED BY: ________________________________ DATE: ____________________

TITLE: ________________________________ PHONE: ( ) ____________________

PLEASE RETURN THE COMPLETED FORM TO:
SUBSEQUENT INJURIES FUND
Division of Workers' Compensation
160 Promenade Circle, #350
Sacramento, CA 95834

DWC SIF 60 3/91

AUTHORIZATION FOR RELEASE OF
SOCIAL SECURITY DISABILITY INSURANCE AWARD

I, ______________________, (Social Security Number: ___________________) hereby grant permission to the Social Security Administration to release a Certificate of Social Security Disability Insurance Award, and information regarding my social security benefits, to the Subsequent Injuries Fund of the State of California, now and at any time in the future.

Dated:____

Applicant Signature:X____

Address:____

____

PLEASE RETURN THE COMPLETED FORM TO:

SUBSEQUENT INJURIES FUND
Division of Workers' Compensation
160 Promenade Circle, #350
Sacramento, CA 95834