Application for Total and Permanent Disability Benefits Form

(HRP15)

Please complete and return this to the GM Benefits & Services Center. ***You must sign and date this form so that your request can be made.*** After you complete the form, please make a copy for your files and return the original and the requested documents in the enclosed postage-paid return envelope or mail to:

GM Benefits & Services Center
PO Box 770003
Cincinnati, OH 45277-0070

For questions regarding the status of your application, please call the GM Benefits & Services Center toll-free at 1-800-489-4646, ask for "Retirement" when prompted by the phone system, Monday through Friday, between 7:30 A.M. and 6:00 P.M., Eastern Time zone, to speak with a Customer Service Associate. From outside the U.S., dial your country's toll-free AT&T Direct® access number then enter 877-833-9900. In the U.S., call 1-800-331-1140 to obtain AT&T Direct access numbers. From anywhere in the world, access numbers are available online at www.att.com/traveler or from your local operator.

TO BE COMPLETED BY THE EMPLOYEE:

I hereby apply for total and permanent disability under applicable provisions of the General Motors Hourly-Rate Employee Pension Plan.

1. Telephone Number (____)____-_____
2. State cause of your disability ______________________________
3. On what date were you first totally disabled by this sickness or injury so that you were wholly unable to work?
   ____/____/____
4. Have you since that time engaged in any occupation or business? ☐ YES ☐ NO
   If yes, state the type of work and the name and address of your employer.
   ____
5. On what date were you first treated by a physician for this disability? ____/____/____
6. Name all physicians who have treated you since the beginning of this disability.

Name	Address (Street, City, State, Zip)	From	To
		/ /	/ /
		/ /	/ /
		/ /	/ /

7. How long have you been confined by this sickness or injury? ____/____/____ ____/____/____
8. If you are married, please provide your Spouse's Date of Birth (MM/DD/YYYY) ____/____/____

9. If you have you been or are now hospitalized in connection with this disability, insert place and dates:

Name of Hospital	From	To
	/ /	/ /
	/ /	/ /
	/ /	/ /

I represent that I have made and read the answers to the foregoing questions and that said answers are true and correct to the best of my knowledge. I herewith authorize any physician or surgeon who has treated or examined me or whom I have consulted for any purpose, and any insurance company or organization to which I have applied for insurance, to divulge and make available to General Motors Corporation, or its designated representatives, any and all information and data or whatsoever kind or character, which they, or any one of them, may have concerning me.

______________________________ **Employee Name** *(please print)*

☐☐☐ ☐☐ ☐☐☐☐ **Employee Social Security number**

______________________________ **Employee Signature**

______________ **Date**

You must sign and date this form.

TO BE COMPLETED BY THE GM BENEFITS & SERVICES CENTER:

/ /		/ /	/ /
Date Eligible	Employee Job Classification	Date Last Worked	Date Form Received

Statement of Employee's Physician Form
(HRP15)

TO BE COMPLETED BY THE EMPLOYEE'S PHYSICIAN (M.D. or D.O.):

1. Full name of the patient ______________________ Age _____ Height _____ Weight _____
2. On what date were you first consulted on account of the present sickness or injury described herein? ___/___/___
3. What are the patient's present symptoms or complaints? ______________________
4. What past history was given to you? ______________________

   ____

   ____

   Give the date of the onset of the illness ___/___/___

5. (A) What treatment has been given? ______________________

   (B) On what date did you last give treatment? ___/___/___

   (C) What was the total number of treatments given on account of this sickness or injury? __________

   (D) Are you the present attending physician? ☐ YES ☐ NO Date of last examination ___/___/___

6. **(A) What is the diagnosis?** ______________________

   ICD9 code (Required)* ______________________

   (B) What is the prognosis? ______________________

7. (A) State the causes of this disability? ______________________

   ____

   ____

   (B) Give objective findings that support your diagnosis ______________________

   ____

   ____

   (C) Were diagnostic studies/tests employed in making diagnosis?

   ☐ YES ☐ NO If yes, please attach pertinent findings/reports

   ____

   ____

8.

   Is an operation advisable ☐ YES ☐ NO

   Has it been advised? ☐ YES ☐ NO

   Is one contemplated? ☐ YES ☐ NO

   If one is contemplated, when? ________ If an operation is not contemplated, why? __________

9. (A) How has the patient reacted to treatment? ______________________

   ____

   (B) Is the patient confined to bed, at home or hospitalized? _______ If so, how long will such confinement be necessary? ______________________

   ____

10. (A) Is the patient able to engage in any occupation or employment for wage or profit? ____________________
(B) If "NO," or answer is qualified, from what date to your personal knowledge, has the patient been continuously so disabled? ____________________
(C) If "YES," or answer is qualified, describe any work limitations? ____________________
____

11. Give the approximate date on which gainful employment of any kind may be expected to be resumed. (If not expected to be able to resume any kind of gainful employment, indicate "NEVER".) ____________________

12. (A) Are you currently providing the patient any medical treatment? ☐ YES ☐ NO
(B) If "YES," what type of treatment? ____________________
(C) If "YES," how long have you been treating this patient for this condition? ____________________
(D) Are you the patient's regular family physician? ☐ YES ☐ NO
(E) If "YES," how long have you been such? ____________________

13. Is the patient mentally capable of transacting his/her personal affairs – for instance, the endorsing of checks – with the realization of the nature and consequence of his/her acts? ____________________
____

Physician Name (Please Print) ____________________ ☐ M.D. ☐ D.O
Address: Number and Street ____________________
City ____________________ State ____________ Zip Code ____________________
Office Phone (_______)______-_______
Specialty ____________________ Board Certified ☐ YES ☐ NO

State License ☐ YES ☐ NO License Number ___________ Date Certified ____/____/____

*** Please note this form will not be processed without the ICD9 Code in Section 6.**

____________________ **Physician Signature** ____________________ **Date**

Physician must sign and date this form.