Benefits Board • Post Office Box 4608 • Cleveland, Tennessee 37320-4608 • (423) 478-7131 • (877) 478-7190

PHYSICIAN'S STATEMENT
FOR
PROOF OF DISABILITY

DIS310

INSTRUCTION TO PHYSICIAN: The claimant named below has applied for disability retirement benefits under the Church of God Ministers' Retirement Plan (the "Plan"). In order to determine whether of not the claimant's condition satisfies the Plan's criteria for disability benefits, it is essential that the Benefits Board receive certain medical information. Please provide complete and clear information concerning the items listed below and return this form to the Benefits Board.

CLAIMANT INFORMATION:

Name: First: _____MI: ____ Last: _____ Member/Ministerial File No.: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____/_____/_____ Telephone No.: _____ Soc. Sec. No.: _____

E-mail address: _____@_____

PHYSICIAN INFORMATION:

Name: _____ Telephone No.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Medical Degree: _____

A. This is to certify that the claimant named above has been under my professional care since:

_____, 20___.

B. In my professional opinion:

(1) _____ It is extremely unlikely that the claimant will be able to resume substantial gainful employment at any time in the foreseeable future.

(2)_____ While the claimant may be able to resume substantial gainful employment by _____, it is unlikely that, at any time in the foreseeable future, the claimant will be able to resume on a substantially full-time basis his/her normal work duties.

(3)_____ The earliest date on which the claimant may reasonably be expected to resume normal work duties is _____. At that time, the following restrictions (if any) on the claimant's return to employment are likely to be applicable:

_____

_____

(4)_____ Other (specify): _____

_____

_____

(5)_____ Please state diagnosis and prognosis: _____

_____

_____

_____

_____

I do hereby affirm that I have carefully read the above and have prepared the information provided herein, that all information is complete and true to the best of my knowledge and belief, and that there are no material facts regarding the claimant's case which are not disclosed.

Signature: _____ Date: _____

Attending Physician

Please return completed form to:

Church of God Benefits Board, Inc.
Post Office Box 4608
Cleveland, TN 37320-4608
• (423) 478-7131 • (877) 478-7190