



# Certification of Disability

Any disability certification other than this form will not be accepted.

**International Union of Operating Engineers Local No. 132 Annuity and Savings Fund**

**457847-01**

## Participant Information

_____	_____	_____
Last Name	First Name	MI
_____		
Address - Number & Street		
_____	_____	_____
City	State	Zip Code
( ) _____		
Daytime Phone		

\_\_\_\_\_

Social Security Number

\_\_\_\_\_

Account Extension (if applicable)

## Required Signatures

I have requested a distribution due to disability. I understand that in order for the payor to reflect my distribution on the appropriate tax reporting form as a distribution due to disability and exempt from the Internal Revenue Service ("IRS") 10% premature distribution tax (if I am under age 59 1/2), I must obtain my physician's or Plan Administrator's signature on the statement below that my disability meets the definition found under Internal Revenue Code §72(m)(7). Such definition provides that a person is disabled "if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration." Federal Treasury regulations provide that the "substantial gainful activity to which §72(m)(7) refers is the activity, or a comparable activity, in which the individual customarily engaged prior to the arising of the disability or prior to retirement if the individual was retired at the time the disability arose."

\_\_\_\_\_

Participant Signature Date

## Certification of Disability

I, \_\_\_\_\_, hereby certify that \_\_\_\_\_  
(Physician's printed name) (Participant's printed name)  
 is my patient, and meets the Internal Revenue Code §72(m)(7) definition of disability as noted above.

\_\_\_\_\_

Physician's Signature Date

**OR**

## Statement of Plan Administrator

I certify that this participant meets the Internal Revenue Code §72(m)(7) definition of disability as noted above.

\_\_\_\_\_

Plan Administrator Signature Date

**Please attach this form to your Distribution/Direct Rollover Request form.**

**Participant** forward to Service Center at:  
 Retirement Service Center  
 PO Box 173764  
 Denver, CO 80217-3764  
**Express Address:**  
 8515 E. Orchard Road, Greenwood Village, CO 80111  
**Phone #:** 1-877-715-4015  
**Fax #:** 1-866-745-5766  
**Web site:** frps.retirementpartner.com

