

Comprehensive Protection Plan Certification of Employee Disability

To receive a payment from the Comprehensive Protection Plan due to disability, the participant and the participant's physician must complete and return this form to Wespath Benefits and Investments (Wespath).

Please note: This form may not be altered in any way or substituted with any other form of disability certification. Any such alteration or substitution is considered invalid and distributions will not be processed.

Part 1 – To be completed by participant

Name _____ Participant # _____
Address _____ Social Security # (last 5 digits) _____

Primary phone # _____
Conference name _____

Part 2 – To be completed by physician

In my medical judgment, as a physician* licensed to practice in the United States, (patient's name) _____
as of (effective date) _____ is unable to engage in his or her own occupation by reason of a medically
determinable physical or mental impairment to be of at least six months duration from its onset. This disability continues as
of the date of this certification.

Physician's name* (printed) _____ Degree _____
State or jurisdiction of medical license _____ Specialty _____
Signature _____ Date _____

Please send this completed certification to Wespath by one of the following methods:

- E-mail (scanned copy) to disabilityteam@wespath.org or
- Fax to **1-847-730-0498** or
- Mail to Wespath Benefits and Investments
1901 Chestnut Avenue
Glenview, IL 60025