

**NOTIFICATION OF CONDITION OF DISABILITY BY PARTICIPANT**

DIS300

**INSTRUCTION:** Use this form to notify the Benefits Board that you believe you have become totally and permanently disabled and are accordingly entitled to disability retirement benefits under the Church of God Ministers' Retirement Plan (the "Plan"). Such evidence of total disability *must* accompany this form as the Benefits Board may require.

**PERSONAL INFORMATION:**

Name: \_\_\_\_\_ Member No.: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

A. Date of accident, or beginning of illness to which you attribute your present condition: \_\_\_\_\_

B. State fully all symptoms of your condition of disability: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. State to what extent you are unable to perform the responsibilities of your employment: \_\_\_\_\_  
\_\_\_\_\_

D. My last day of employment was on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

E. Attached hereto is evidence of my condition of total and permanent disability consisting of:

\_\_\_\_\_ Notification of award of disability retirement benefits under the Federal Social Security Act.

\_\_\_\_\_ Notification of determination of total and permanent disability by an insurance carrier providing such benefits under long-term disability income coverage applicable to me.

\_\_\_\_\_ Physician's statement.

\_\_\_\_\_ Other (specify): \_\_\_\_\_

I understand that the provisions of the Plan are specific as to the requirements for disability retirement benefits, and that the Benefits Board may require additional evidence of disability before certifying the existence of that condition. I will provide such additional evidence as may be required, agree to submit to examination by one or more medical practitioners selected by the Benefits Board, and consent to the release by any such practitioner to the Benefits Board of all data and finding resulting from any such examinations.

Member's signature \_\_\_\_\_ Date: \_\_\_\_\_

.....  
**DO NOT WRITE BELOW THIS LINE**

Date approved \_\_\_\_\_ Disability retirement benefits to begin \_\_\_\_\_, 20\_\_.

Signed \_\_\_\_\_  
President and CEO