IAM NATIONAL PENSION FUND

PHYSICIAN'S STATEMENT

Note to Healthcare Provider: A completed physician's statement is required to evaluate an agent's request to manage a participant or beneficiary's pension account. A physician, psychiatrist, psychologist, physician assistant, or registered nurse must complete and sign this form. Please answer all the following questions on this form or provide the following information on your letterhead.

Definition of Incapacity: For the purposes of this form, "Incapacitated" means "the inability of an individual to manage his or her property or financial affairs due to a medical condition impairing their cognitive functions, e.g., dementia, Alzheimer's, etc."

1. I certify that _____ ("Patient") was under my professional and/or medical care from _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY).

2. In my professional opinion, within a reasonable degree of medical certainty, the Patient:

   ☐ has the capacity to make responsible decisions concerning the Patient's own financial affairs.
   ☐ is incapacitated according to the definition given above, commencing _____ (MM/YYYY).

3. Upon examination on _____ (MM/DD/YYYY), I determined that the medical diagnoses affecting the Patient's capacity to manage their own financial affairs are as follows:

   _____

   _____

   _____

   The condition(s) impacting the Patient's capacity are:

   ☐ permanent ☐ temporary ☐ indeterminable (please explain below).

   _____

I affirm upon personal knowledge that the contents of this document are true.

Print Name of Physician/Psychiatrist/Psychologist/PA/RN	Signature	License Number
Name of Facility (if applicable)	Name of Supervising Physician (if PA)	

Telephone Number	Address	State