ANNUAL PHYSICAL VERIFICATION

PLEASE PRINT. Once completed, please fax to MoKan Sheet Metal Workers Welfare Fund.
Fax # (816) 836-6553 or Alt. Fax # (816) 753-7252

Name (Last, First, MI):		**MOKAN #: KDLMOKA___________**	
Home Address:	**City:**	**State:**	**Zip:**
Physician's Name:		**Phone:**	
Physician's Address:	**City:**	**State:**	**Zip:**

I am verifying that I obtained an annual physical to meet MoKan Sheet Metal Workers Welfare Fund requirements in 2020. I understand that to earn $375.00 in 2020, I, as a member of the MOKAN health plan, must do the following:

- Obtain an annual physical between **January 2020 and December 2020.**

I acknowledge the physician must determine what examinations and tests are indicated for the patient based on medical standards of care and the patient's personal health history. Generally, well exams include weight and blood pressure checks, ear, nose and throat exams, and basic blood tests.

I hereby declare under penalty of perjury that the information on this form is correct and complete to the best of my knowledge. I understand that if any incorrect or misleading information on this form results in a loss to the Fund, the Fund is entitled to recover the amount of such loss from me or by withholding from my future benefits.

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Member or Spouse Signature   Date

I hereby attest and agree that the above patient was given a thorough physical examination compliant with the standards of care applicable to his/her age, gender, and personal health history.

Date of the Physical: ______________

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Physician Signature   Date