COVENANT PENSION TRUST
THE EVANGELICAL COVENANT CHURCH

FORM E
# STATEMENT OF HEALTH

*For use with Participant Form D: Surviving Spouse Benefit if Form D submitted after participant has turned age 63 and before pension benefit payments have begun.*

## Participant Name _____
FIRST / MIDDLE / LAST

ADDRESS _____
STREET

_____
CITY STATE/PROVINCE ZIP

PHONE _____ DATE OF BIRTH _____ EMAIL _____

## Physician's Statement

**I certify that the patient listed above was examined by me**

**on _____ and found**

**to be in good health for his/her age.**

Signature of physician _____ Date signed _____

Please print physician's name _____
FIRST / MIDDLE / LAST

ADDRESS _____
STREET

_____
CITY STATE/PROVINCE ZIP

Patient (Plan Participant)'s Signature _____ Date signed _____

**Return forms by fax to number listed below, or by mail. Do not email.**



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