Amalgamated Transit Union Local 1596 Pension Fund

Application for Disability Benefits

PLEASE PRINT OR TYPE:

1) Name of Applicant: _____,_____,_____
(Last) (First) (Middle)

Social Security Number: _____

Date of Birth: _____
(Attach birth certificate or other proof)

Home Phone Number (____)_____ Cell Phone Number (___)_____

Home Address: _____
(Street Address)

_____
(City) (State) (Zip)

2) Are you currently married? Yes _____ No _____

If yes, please complete the following:

Name of Spouse: _____,_____,_____
(Last) (First) (Middle)

Spouse's Social Security Number: _____

Spouse's Date of Birth: _____ (attach proof of date of birth)

If no, please complete the following:

Name of Joint Beneficiary: _____,_____,_____
(Last) (First) (Middle)

Beneficiary Social Security Number: _____

Beneficiary Date of Birth: _____ (attach proof of date of birth)

Relationship: _____

3) Date of Hire by the LYNX: _____

Current position held by the LYNX: _____

4) I plan to retire on: _____
(Month-Day-Year)

5) Type of retirement for which you are applying: (check one)

_____ Line-of-Duty Disability _____ Non-Line-of-Duty Disability

6) If you are applying for a Disability Benefit, please complete the following:

a. Date disability commenced: _____
(Month-Day-Year)

b. Nature and cause of disability: _____

_____

_____

_____

c. Did your disability result from any of the following:

	YES	NO
(1) Use of drugs, intoxicants or narcotics?	_____	_____
(2) Due to a fight, riot, civil insurrection or crime?	_____	_____
(3) From an injury or disease sustained while you were serving in any armed forces?	_____	_____
(4) After your employment with the LYNX was terminated?	_____	_____
(5) While working for anyone other than the LYNX and arising out of such employment?	_____	_____
d. A copy of my doctors' medical opinion is attached:	_____	_____

NOTE: If you are applying for a disability benefit, records must be filed, including copies of a doctor's opinion, narrative explanation of the current accident, medical records and other documentation to show that the disability is total and permanent. If application is made for a line-of-duty disability, copies of worker's compensation records and other documentation must also be filed to show the disability occurred while performing service related duties. Also, the Board of Trustees may require you to be examined by a doctor selected by the Board.

ACKNOWLEDGMENTS

I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me for benefits.

I have reviewed the Designation of Beneficiary Form filed with the Board of Trustees and I hereby certify it's accuracy. If I desire to change my designated beneficiary(ies), I will file a new Designation of Beneficiary Form with this Application.

I hereby authorize the release of any and all medical records including but not limited to the complete history records in possession of all doctors listed below concerning my illness and/or treatment.

I hereby waive my right of confidentiality of my medical records and other medical evidence *in order that my application for disability benefits may be properly processed.* I understand that in so doing, such records will be discussed during one or more public meetings and will become public record. I understand that the Board(s) will rely upon this waiver and that I will not be able to withdraw same at a later date.

I agree to cooperate fully with the Board of Trustees of the ATU LOCAL 1596 PENSION PLAN in making available to the Board, or authorized agents of the Board, information which reasonable relates to the initial payments of or continuing eligibility for payments of benefits form the Fund.

I understand that, if my application is approved, I will be required to complete an annual medical review by a physician selected by the Board of Trustees, unless I qualify to receive disability benefits under SSI. If I do qualify to receive disability benefits under SSI, then I will be required to submit proof of such benefits annually as a condition to receiving continued benefits under the Plan.

I hereby agree to indemnify and hold harmless ATU LOCAL 1596 PENSION PLAN from and against any and all claims, demands, or causes of action of any kind or nature resulting from or in connection ATU LOCAL 1596 PENSION PLAN release of the results of the undersigned's annual physical to the Pension Fund and from and against any resulting losses, costs, expenses, reasonable attorneys' fees, liability, damages, orders, judgments, or decrees in connections therewith.

_____ _____

Signature of Applicant (requires notarization below) Date

STATE OF _____

COUNTY OF _____

BEFORE ME, the undersigned authority, personally appeared _____, who is personally known to me or has produced _____ as identification and who did take an oath and, after being duly cautioned and sworn, deposes and says that he/ she has signed the foregoing document for the reasons therein contained.

SWORN TO AND SUBSCRIBED before me this the _____ day of _____, ____.

_____

Notary Public

My Commission Expires: _____

My Commission Number Is: _____

Return to: ATU Local 1596 Pension Fund, 4360 Northlake Boulevard, Suite 206, Palm Beach Gardens, FL 33410

EFT Direct Deposit Authorization
(PLEASE PRINT LEGIBLY OR TYPE)

Plan Name: ATU Local 1596 Pension Plan

Name: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

I authorize the ***Pension Plan*** and the Resource Centers LLC to initiate Direct Deposits (credit entries) to my financial institution account indicated below. This authorization will remain in full force and effect until I notify the Pension Plan in writing to change or cancel the authorization. Any changes to this authorization must be received by the Pension Fund no later than the 12th of the month to take effect on the 1st of the following month. All new account information will be pre-noted before the change will take effect; therefore, you may receive a paper check for one month before the new account information is verified and processed. I have verified my address on file to avoid any delay in processing reimbursements. I have also attached a VOID check for the deposit account (**Starter checks are not acceptable**).

I authorize the ***Pension Plan*** and the Resource Centers LLC to recover money deposited electronically in my account in error, either by adjusting the account or withholding any future payments. I understand that I will be notified by the ***Pension Plan*** before adjustments are made. I have notified any joint account holder(s) of the obligation to repay any overpayment to this account after my death if the overpayment is not repaid by the financial institution.

_____ _____

(Member Signature - *MUST BE SIGNED IN PRESENCE OF A NOTARY*) (Date)

A. CHECKING:

Institution: _____ Branch: _____
City: _____ State: _____
Routing/ABA No: _____ Account No: _____

B. SAVINGS:

Institution: _____ Branch: _____
City: _____ State: _____
Routing/ABA No: _____ Account No: _____

Please Attach a "VOID" Check or Letter from Your Financial Institution or Account

Requests will not be processed without a VOID check or a letter from the financial institution or bank. The check or typed confirmation from the financial institution MUST have the following information: checking or savings account number, bank routing number, and the account owner(s) name. Starter checks are not acceptable.

PLAN ADMINISTRATOR: THE RESOURCE CENTERS, LLC
4360 Northlake Boulevard, Suite 206 ❖ Palm Beach Gardens, FL 33410 ❖ Phone: (800) 206-0116

STATE OF

COUNTY OF

BEFORE ME, the undersigned authority, appeared before me _____ by means of □ physical presence □ online notarization and who is □ personally known to me or □ has produced _____ as identification, and who did take an oath and, after being duly cautioned and sworn, deposes and says that he/ she has signed the foregoing document for the reasons therein contained.

SWORN TO AND SUBSCRIBED before me this the _____ day of _____, _____.

_____

Notary Public, State of Florida
At Large

My Commission Expires:

My Commission Number Is:

Return Completed Form to:

Resource Centers, LLC
4360 Northlake Boulevard Suite 206
Palm Beach Gardens, FL 33410
Fax: 561-624-3278 Email: ClientServices@ResourceCenters.com

Form **W-4P**

Department of the Treasury
Internal Revenue Service

Withholding Certificate for Periodic Pension or Annuity Payments

Give Form W-4P to the payer of your pension or annuity payments.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See pages 2 and 3 for more information on each step and how to elect to have no federal income tax withheld (if permitted).

Step 2: Income From a Job and/or Multiple Pensions/ Annuities (Including a Spouse's Job/ Pension/ Annuity)

Complete this step if you (1) have income from a job or more than one pension/annuity, or (2) are married filing jointly and your spouse receives income from a job or a pension/annuity. **See page 2 for examples on how to complete Step 2.**

Do **only one** of the following.

(a) Reserved for future use.

(b) Complete the items below.

(i) If you (and/or your spouse) have one or more jobs, then enter the total taxable annual pay from all jobs, plus any income entered on Form W-4, Step 4(a), for the jobs less the deductions entered on Form W-4, Step 4(b), for the jobs. Otherwise, enter "-0-" . . . $

(ii) If you (and/or your spouse) have any other pensions/annuities that pay less annually than this one, then enter the total annual taxable payments from all lower-paying pensions/ annuities. Otherwise, enter "-0-" . . . . . $

(iii) Add the amounts from items (i) and (ii) and enter the **total** here . . . . . $

TIP: To be accurate, submit a new Form W-4P for all other pensions/annuities if you haven't updated your withholding since 2021 or this is a new pension/annuity that pays less than the other(s). Submit a new Form W-4 for your job(s) if you have not updated your withholding since 2019. If you have self-employment income, see page 2.

Complete Steps 3–4(b) on this form only if (b)(i) is blank **and** this pension/annuity pays the most annually. Otherwise, do not complete Steps 3–4(b) on this form.

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $

Multiply the number of other dependents by $500 . . . . . $

Add other credits, such as foreign tax credit and education tax credits $

Add the amounts for qualifying children, other dependents, and other credits and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs or pension/annuity payments). If you want tax withheld on other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, taxable social security, and dividends . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the basic standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld from **each payment** . **4(c)** $

Step 5: Sign Here

Your signature (This form is not valid unless you sign it.) **Date**

General Instructions

Section references are to the Internal Revenue Code.

Future developments. For the latest information about any future developments related to Form W-4P, such as legislation enacted after it was published, go to *www.irs.gov/FormW4P*.

Purpose of form. Complete Form W-4P to have payers withhold the correct amount of federal income tax from your periodic pension, annuity (including commercial annuities), profit-sharing and stock bonus plan, or IRA payments. Federal income tax withholding applies to the taxable part of these payments. Periodic payments are made in installments at regular intervals (for example, annually, quarterly, or monthly) over a period of more than 1 year. Don't use Form W-4P for a nonperiodic payment (note that distributions from an IRA that are payable on demand are treated as nonperiodic payments) or an eligible rollover distribution (including a lump-sum pension payment). Instead, use Form W-4R, Withholding Certificate for Nonperiodic Payments and Eligible Rollover Distributions, for these payments/distributions. For more information on withholding, see Pub. 505, Tax Withholding and Estimated Tax.

Choosing not to have income tax withheld. You can choose not to have federal income tax withheld from your payments by writing "No Withholding" on Form W-4P in the space below Step 4(c). Then, complete Steps 1a, 1b, and 5. Generally, if you are a U.S. citizen or a resident alien, you are not permitted to elect not to have federal income tax withheld on payments to be delivered outside the United States and its territories.

Caution: If you have too little tax withheld, you will generally owe tax when you file your tax return and may owe a penalty unless you make timely payments of estimated tax. If too much tax is withheld, you will generally be due a refund when you file your tax return. If your tax situation changes, or you chose not to have federal income tax withheld and you now want withholding, you should submit a new Form W-4P.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you (or you and your spouse) receive. If you do not have a job and want to pay these taxes through withholding from your payments, you should enter the self-employment income in Step 4(a). Then compute your self-employment tax, divide that tax by the number of payments remaining in the year, and include that resulting amount per payment in Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if your self-employment income multiplied by 0.9235 is over $160,200.

Payments to nonresident aliens and foreign estates. Do not use Form W-4P. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities, and Pub. 519, U.S. Tax Guide for Aliens, for more information.

Tax relief for victims of terrorist attacks. If your disability payments for injuries incurred as a direct result of a terrorist attack are not taxable, write "No Withholding" in the space below Step 4(c). See Pub. 3920, Tax Relief for Victims of Terrorist Attacks, for more details.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you have at least one of the following: income from a job, income from more than one pension/annuity, and/or a spouse (if married filing jointly) that receives income from a job/pension/annuity. The following examples will assist you in completing Step 2.

Example 1. Bob, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Bob also has a job that pays $25,000 a year. Bob has no other pensions or annuities. Bob will enter $25,000 in Step 2(b)(i) and in Step 2(b)(iii).

If Bob also has $1,000 of interest income, which he entered on Form W-4, Step 4(a), then he will instead enter $26,000 in Step 2(b)(i) and in Step 2(b)(iii). He will make no entries in Step 4(a) on this Form W-4P.

Example 2. Carol, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Carol does not have a job, but she also receives another pension for $25,000 a year (which pays less annually than the $50,000 pension). Carol will enter $25,000 in Step 2(b)(ii) and in Step 2(b)(iii).

If Carol also has $1,000 of interest income, then she will enter $1,000 in Step 4(a) of this Form W-4P.

Example 3. Don, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Don does not have a job, but he receives another pension for $75,000 a year (which pays more annually than the $50,000 pension). Don will not enter any amounts in Step 2.

If Don also has $1,000 of interest income, he won't enter that amount on this Form W-4P because he entered the $1,000 on the Form W-4P for the higher paying $75,000 pension.

Example 4. Ann, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Ann also has a job that pays $25,000 a year and another pension that pays $20,000 a year. Ann will enter $25,000 in Step 2(b)(i), $20,000 in Step 2(b)(ii), and $45,000 in Step 2(b)(iii).

If Ann also has $1,000 of interest income, which she entered on Form W-4, Step 4(a), she will instead enter $26,000 in Step 2(b)(i), leave Step 2(b)(ii) unchanged, and enter $46,000 in Step 2(b)(iii). She will make no entries in Step 4(a) of this Form W-4P.

If you are married filing jointly, the entries described above do not change if your spouse is the one who has the job or the other pension/annuity instead of you.

CAUTION ***Multiple sources of pensions/annuities or jobs.*** *If you (or if married filing jointly, you and/or your spouse) have a job(s), do NOT complete Steps 3 through 4(b) on Form W-4P. Instead, complete Steps 3 through 4(b) on the Form W-4 for the job. If you (or if married filing jointly, you and your spouse) do not have a job, complete Steps 3 through 4(b) on Form W-4P for* ***only*** *the pension/annuity that pays the most annually. Leave those steps blank for the other pensions/annuities.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. Including these credits will increase your payments and reduce the amount of any refund you may receive when you file your tax return.

Specific Instructions *(continued)*

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include amounts from any job(s) or pension/annuity payments. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your pension, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 6, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes itemized deductions, the additional standard deduction for those 65 and over, and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from **each payment**. Entering an amount here will reduce your payments and will either increase your refund or reduce any amount of tax that you owe.

Note: If you don't give Form W-4P to your payer, you don't provide an SSN, or the IRS notifies the payer that you gave an incorrect SSN, then the payer will withhold tax from your payments as if your filing status is single with no adjustments in Steps 2 through 4. For payments that began before 2023, your current withholding election (or your default rate) remains in effect unless you submit a new Form W-4P.

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1	Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income	**1**	$
2	Enter: • $27,700 if you're married filing jointly or a qualifying surviving spouse • $20,800 if you're head of household • $13,850 if you're single or married filing separately	**2**	$
3	If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-"	**3**	$
4	If line 3 equals zero, and you (or your spouse) are 65 or older, enter: • $1,850 if you're single or head of household. • $1,500 if you're married filing separately. • $1,500 if you're a qualifying surviving spouse or you're married filing jointly and one of you is under age 65. • $3,000 if you're married filing jointly and both of you are age 65 or older. Otherwise, enter "-0-". See Pub. 505 for more information	**4**	$
5	Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information	**5**	$
6	**Add** lines 3 through 5. Enter the result here and in **Step 4(b)** on Form W-4P	**6**	$

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. You are required to provide this information only if you want to (a) request federal income tax withholding from pension or annuity payments based on your filing status and adjustments; (b) request additional federal income tax withholding from your pension or annuity payments; (c) choose not to have federal income tax withheld, when permitted; or (d) change a previous Form W-4P. To do any of the aforementioned, you are required by sections 3405(e) and 6109 and their regulations to provide the information requested on this form. Failure to provide this information may result in inaccurate withholding on your payment(s). Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

ATU LOCAL 1596 PENSION PLAN

AUTHORIZATION TO RELEASE MEDICAL RECORDS
AND HOLD HARMLESS

This is to certify that as a part of the undersigned's disability application process with the ATU Local 1596 Pension Plan, the Board of Trustees may require a physical examination in compliance with the Americans with Disabilities Act of 1992.

The undersigned hereby directs ATU Local 1596 Pension Plan and Pension Resource Center to release, if requested, the results of the undersigned's medical records to the Board of Trustees of the ATU Local 1596 Pension Plan or its designee. This information may be used by the Pension Plan as the undersigned makes a claim for a duty disability pension.

The undersigned agrees to indemnify and hold harmless ATU Local 1596 Pension Plan and the Pension Resource Center from and against any and all claims, demands, or causes of action of any kind or nature resulting from or in connection with the release of the undersigned's medical records to the Pension Plan and from and against any resulting losses, costs, expenses, reasonable attorneys' fees, liabilities, damages, orders, judgments or decrees in connection therewith.

The undersigned has read and fully understands the terms and conditions of this affidavit.

WITNESSES: SIGNATURE:

_____ _____

_____ _____
(Print Name)

WPBFF.Pen
newhire.rel

PLEASE RETURN TO:

ATU Local 1596 Pension Plan
C/O PENSION RESOURCE CENTER
4360 NORTH LAKE BOULEVARD, SUITE 206
PALM BEACH GARDENS, FL 33410

DISABILITY APPLICANT QUESTIONNAIRE

IF YOUR CLAIM IS BASED ON AN INJURY,
PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Please describe exactly how you were injured, providing specifics as to:

   a. Date.

   b. Time.

   c. Place.

   d. Provide names and addresses of all witnesses.

   e. Nature of your injury or injuries.

2. Was the injury reported to your department and if so, state the date reported and to whom.

3. Please state whether you are claiming the injury to be:

   a. Total and Permanent. [ ] Yes [ ] No

   b. Service-related. [ ] Yes [ ] No

   c. Non-service related. [ ] Yes [ ] No

   d. Provide your reasons for the above claims.

4. Please specifically describe any and all previous conditions that you have had, even though they may not be directly associated with the condition on which your claim is based.

a. Specifically state when you had these conditions.

b. Provide names, addresses and phone numbers of all health care providers (including chiropractors) whom you consulted or who treated you for the previous condition(s).

c. Provide the diagnosis.

d. Provide the prognosis.

e. Provide the dates of treatment.

f. Provide the nature of treatment.

g. Provide the medications prescribed.

h. Provide the names, addresses and telephone numbers of all persons who may have knowledge of such condition.

5. **Please provide the names, addresses and telephone numbers of <u>all</u> physicians, surgeons, hospitals, chiropractors, osteopaths and other health care providers who have treated you for the condition upon which your claim is based and any condition that <u>may</u> be related to it.**

a. Provide a brief description of what you were treated for.

b. Provide the diagnosis.

c. Provide the prognosis.

d. Provide the dates of treatment.

e. Provide the nature of treatment.

f. Provide the medications prescribed.

g. Provide the names, addresses and telephone numbers of <u>all</u> persons who may have knowledge of these conditions.

6. Have you ever been involved in an automobile or other vehicular accident? If so, please provide:

a. When the accident occurred.

b. Where the accident occurred.

c. How the accident occurred.

d. Whether you were injured.

e. How you were injured.

f. Was this accident job related?

g. Names, addresses and telephone numbers of <u>all</u> health care providers who treated you.

h. Diagnosis.

i. Prognosis.

j. Medications prescribed.

k. Nature of treatment.

l. Dates of treatment.

m. Provide the names, addresses and telephone numbers of all who may have knowledge of the injuries resulting from the accident.

7. Have you ever had a fall, collision, sports injury, accident, etc. which required treatment by a health care provider? If so, please provide:

a. A description of the incident.

b. When it occurred.

c. How it occurred.

d. Where it occurred.

e. How you were injured.

f. Names, addresses and telephone numbers of all health care providers who treated you.

g. Diagnosis.

h. Prognosis.

i. Medications prescribed.

j. Nature of treatment.

k. Dates of treatment.

l. Provide the names, addresses and telephone numbers of all persons who may have knowledge of the injuries resulting from the incident.

8. Please provide the names, addresses and dates of all your prior and current employers, and provide:

a. The nature of the work involved with each employment.

b. The status (i.e. terminated, continuing, etc.) of each employment.

c. State the basis or reason for such status.

9. Please state whether you are now or ever have been self employed, and if so, state the nature of the work.

10. Were you suffering any injury, disease, or disability at the time of the accident(s), incident(s), or condition(s) for which you are now applying for disability retirement? If so , what was the nature of the injury, disease or disability?

11. Describe all records of the accident(s) or incident(s) forming the basis of your application for disability retirement, including but not limited to, traffic accident reports, police reports, notice of injury reports, log books, hospital/clinic records, doctor's records, disciplinary records, etc.

12. Provide the name and addresses of all health care providers who have advised you that you are permanently and totally incapable of performing useful and efficient service, either physically or mentally, in the position you hold with Palm Tran as a result of the injury or condition for which you seek disability retirement.

13. Provide the name and addresses of all health care providers who have advised you that you are not permanently and totally incapable of performing useful and efficient service, either physically or mentally, to provide services in the job position you hold for Palm Tran as a result of the injury or condition for which you seek disability retirement.

14. State the date on which you reached maximum medical improvement (MMI) for workers' compensation purposes, and provide the names and addresses of all health care providers who have advised that you have reached maximum medical improvement (MMI).

15. Provide the names and addresses of all health care providers who have advised that you have not reached maximum medical improvement (MMI).

16. Is the injury which you are now claiming permanently and totally prevents you, physically or mentally, from performing useful and efficient service in the position you hold for Palm Tran in any way related to any other injury, disease, condition or disability? If yes, explain.

17. Has your sworn statement or deposition ever been taken in connection with any claim arising out of the injury or disability for which you seek disability retirement? If so, state the date taken and by whom.

18. Is there any other information known to you, your agents and attorneys, which might be relevant to your application for disability retirement? If so, specify.

19. Have you ever applied for worker's compensation benefits in any jurisdiction? If so, please state for each application:

a. The name and address of the employer.

b. The date of the application.

c. Determination of the application.

d. The dates of receipt of benefits.

20. Describe in detail why you feel that you are permanently and totally unable physically or mentally, from performing useful and efficient service as a _____.

YOU ARE REQUIRED TO SUPPLEMENT THIS QUESTIONNAIRE IMMEDIATELY IN WRITING TO THE BOARD ATTORNEY WITH ANY NEW OR ADDITIONAL INFORMATION OBTAINED BETWEEN THE TIME OF SIGNING THIS QUESTIONNAIRE AND FINAL DECISION BY THE BOARD OF TRUSTEES.

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED HEREIN IS TRUE AND COMPLETE. I UNDERSTAND THAT IT IS A CRIME FOR A PERSON WILLFULLY AND KNOWINGLY TO MAKE, OR CAUSE TO BE MADE, OR TO ASSIST, CONSPIRE WITH, OR URGE ANOTHER TO MAKE, OR CAUSE TO BE MADE, ANY FALSE, FRAUDULENT, OR MISLEADING ORAL OR WRITTEN STATEMENT OR WITHHOLD OR CONCEAL MATERIAL INFORMATION TO OBTAIN ANY BENEFIT AVAILABLE UNDER THE PENSION PLAN. IN ADDITION TO ANY APPLICABLE CRIMINAL PENALTY UPON CONVICTION FOR A VIOLATION DESCRIBED ABOVE, I MAY IN THE DISCRETION OF THE BOARD OF TRUSTEES, BE REQUIRED TO FORFEIT THE RIGHT TO RECEIVE ANY OR ALL BENEFITS TO WHICH I WOULD OTHERWISE BE ENTITLED. FOR PURPOSES HEREOF, "CONVICTION" MEANS A DETERMINATION OF GUILT THAT IS THE RESULT OF A PLEA OR TRIAL, REGARDLESS OF WHETHER ADJUDICATION IS WITHHELD.

DATED this _____ day of _____, 2008.

_____

Applicant's Signature

Print Name:_____

FORMS\DisabilityApplicant.Questn

Authorization to Use or Disclose Health Information

Name:_____ Date of Birth:_____

I HEREBY AUTHORIZE the disclosure to and the use of the above named individual's health information as described below.

1. The following individual(s) or organization(s) are authorized to make the disclosure:

   Any and all Physicians, Facilities and/or Hospitals who have provided treatment.

2. The type of information to be used or disclosed is my entire medical/health record.

3. I understand that the information in my medical/health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. The information identified above may be used by or disclosed to:

Name of Client	ATU Local 1596 Pension Fund c/o Sugarman & Susskind, P.A.
Address of Client	100 Miracle Mile Suite 300 Coral Gables, FL. 33134

5. This information for which I'm authorizing disclosure will be used for the following purpose:

To facilitate the Board of Trustees of the **ATU Local 1596 Pension Fund** in the carrying out its duty to review, discuss and determine my application for disability retirement. I hereby waive the right of confidentiality of medical/health records and other medical evidence in the custody of the Board of Trustees or elsewhere. I further understand that such records will be discussed during one or more public meetings and will become public record. I understand that the Board of Trustees will rely upon this waiver.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical/health care provider. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my insurance policy.

7. This authorization will expire six months from the date on which it was signed.

8. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

10. I also authorize the use of photocopy of this document in place of the original.

_____ _____

Signature of patient or legal representative Date

If signed by legal representative, relationship to patient:_____

Signature of witness:_____ _____

Date