FT. PIERCE POLICE OFFICERS' RETIREMENT TRUST FUND
APPLICATION FOR PENSION BENEFITS

PLEASE PRINT OR TYPE:

1. a. Name of Employee: _____

b. Social Security Number: _____
* In accordance with the provisions of §119.071(5)(a)6g, Florida Statutes, the collection and use of social security numbers is authorized for the purpose of the administration of the pension fund.

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

d. Home Telephone Number: (___) _____

e. Home Address: _____

_____

f. Permanent address to which check and correspondence should be sent:
(It is important to keep your address and phone number updated - please notify us of any changes)

_____

_____

2. a. Are you currently married? Yes_____ No_____

If yes, please complete the following:

b. Name of Spouse: _____

c. Spouse's Social Security Number: _____
* In accordance with the provisions of §119.071(5)(a)6g, Florida Statutes, the collection and use of social security numbers is authorized for the purpose of the administration of the pension fund.

d. Spouse's Date of Birth: _____ (Attach birth certificate or other proof)

e. Date of Marriage: _____

3. Names and Dates of Birth of Child(ren):

Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

(Attach additional page, if needed)

4. Names of Your Living Parents:

a. Mother: _____

b. Father: _____

5. a. Date of hire by Fort Pierce as Police Officer: _____

b. Current Position in the Police Department: _____

6. I plan to retire on: _____

7. Type of retirement for which you are applying:

_____ Normal Retirement

_____ Deferred Retirement Option Plan. Please be advised that the guarantee of ten (10) years retirement annuity payments commences upon the retiree's entrance into DROP.

_____ Early Retirement

_____ Line-of-Duty Disability

_____ Non-Line-of-Duty Disability

8. If you are applying for a disability retirement, please complete the following:

a. Date disability commenced:_____

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 City terminated?	_____	_____
(5)	While working for anyone other than the City and arising out of such employment?	_____	_____

d. A copy of my doctor's medical opinion is attached: _____ _____

NOTE: If you are applying for a disability benefit, records must be filed to show that the disability is total and permanent. If application is made for a line-of-duty disability, copies of workers' compensation records must also be filed to show that the disability occurred in the line-of-duty. Also, the Board of Trustees may require you to be examined by a doctor selected by the Board.

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.

FOR DISABILITY APPLICATIONS ONLY:

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. A copy of this document will be treated in the same manner and have the same effect as an original.

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 Ft. Pierce Police Officers' Retirement Trust Fund in making available to the Board, or authorized agents of the Board, information which reasonably relates to the initial payment of or continuing eligibility for payment of benefits from the Fund.

I hereby agree to indemnify and hold harmless the City of Ft. Pierce and the Pension Fund and against any and all claims, demands, or causes of action of any kind or nature resulting from or in connection with the City of Ft. Pierce's release of the results of the undersigned's annual physical 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.

THIS SPACE INTENTIONALLY LEFT BLANK

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

This Application revokes any prior Applications.

_____ _____
PARTICIPANT'S SIGNATURE DATE

STATE OF FLORIDA
COUNTY OF _____

SWORN TO (or affirmed) and subscribed before me, this _____ day of _____, 20__ by _____, who is

_____ Personally known
_____ **OR** Who Produced Identification

Type of Identification Produced: _____

_____

_____
Notary Signature
Print, type or stamp name of Notary below in addition to seal:

_____

NOTARY SEAL]

BSJ/pah
March 17, 2014
H:\Ft Pierce Pol 1155\FORMS\(2014) PENSION APPLICATION.wpd

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, Psychiatrist/Psychologists, 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 records 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: Ft. Pierce Police Officers' Retirement Trust Fund
   c/o Klausner Kaufman Jensen & Levinson
   Address: 7080 N.W. 4th Street
   Plantation, FL 33317

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

   To facilitate the Board of Trustees of the 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 at the end of my disability case before the Board.

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.

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

Ft. Pierce Police Officers' Retirement Trust Fund
INTERROGATORIES FOR DISABILITY PENSION BENEFITS

PLEASE PRINT OR TYPE

Name of Employee: _____
(Last) (First) (MI)

Date of Birth: _____ (Attach proof)
Month-Day-Year

Home Telephone Number: _____
(Area Code) Number

Home Address: _____
Number Street

_____
City/Town State Zip Code

PLEASE ANSER ALL QUESTIONS UNDER OATH:

1. Please describe exactly how you were injured/contracted illness, providing specifics as to date, time and place:

   a. Provide names and addresses of all witnesses.

   b. Nature of your injury/illness.

2. Was injury/illness reported to Ft. Pierce Police Department and if so, state date reported and to whom:

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

   a. Total and Permanent [ ] Yes [ ] No

   b. Service Related [ ] Yes [ ] No

   c. Non-Service Related [ ] Yes [ ] No

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. For each condition, provide the following (attach a separate sheet if necessary):

   a. Specifically when you had the condition.

   b. Names, addresses and phone numbers of all health care providers with whom you have consulted or who treated you.

   c. The diagnosis.

   d. The prognosis.

   e. Dates of treatment.

   f. Nature of treatment.

   g. Medications prescribed

   h. 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 all health care providers who have treated you for the condition upon which your claim is based and any condition related to it. Please provide the following:

a. A brief description of what you were treated for

b. The diagnosis

c. The prognosis

d. Dates of treatment

e. Nature of treatment.

f. Medications prescribed.

g. Names, addresses and telephone numbers of all persons who may have knowledge of such condition.

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

a. When accident occurred:

b. Where and when accident occurred:

c. How accident occurred:

d. Whether you were injured:

e. How you were injured:

f. Was accident job related:

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

(1) Diagnosis

(2) Prognosis

(3) Medications prescribed.

(4) Nature of treatment.

(5) Dates of treatment.

(2) Names, addresses and telephone numbers of all persons who may have knowledge of injuries resulting from the accident.

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

a. A description of the incident:

b. Where and when it occurred:

c. How it occurred:

d. Whether you were injured:

e. How you were injured:

f. Was it job related:

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

(1) Diagnosis

(2) Prognosis

(3) Medications prescribed.

(4) Nature of treatment.

(5) Dates of treatment.

(6) Names, addresses and telephone numbers of all persons who may have knowledge of injuries resulting from the accident.

8. Please provide names, addresses and dates of all prior and current employers, including self-employment.

a. Nature of work involved with employment.

b. Status of each employment (terminated, retired, continuing, etc)

c. Basis or reason for any termination of employment.

9. Were you suffering any injury/illness, disease, or disability at the time of the accident, incident or condition for which you are applying for disability retirement?

10. Describe all records of the accident or incident forming the basis of your application, including, traffic accident reports, police reports, notice of injury/illness, hospital records etc.

11. Provide the name and address of all health care providers who have advised you that you are permanently and totally incapable of performing useful and efficient service as a Police Officer as a result of the condition or injury/illness which is the basis of your claim for disability retirement.

12. Provide the name and address of all health care providers who have advised you that you are **not** permanently and totally incapable of performing useful and efficient service as a Police Officer as a result of the condition or injury/illness which is the basis of your claim for disability retirement.

13. 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 MMI.

14. Provide the names and addresses of all health care providers who have advised that you have **not** reached MMI.

15. Has you sworn statement or testimony been taken in connection with any claim arising out of the injury/illness or condition which is the basis for your claim for disability. If so, state the date taken and by whom.

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

17. Have you ever applied for workers' 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.

18. Describe in detail why you feel that you are permanently and totally unable physically or mentally from performing useful and efficient service as a Police Officer.

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 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 hereby agree to indemnify and hold harmless the Pension Plan from and against any and all claims, demands, or causes of action of any kind or nature resulting from or in connection with the Board's use of my medical records to process my application, and from and against any resulting losses, costs, expenses, reasonable attorneys' fees, liabilities, damages, orders, judgments, or decrees in connection therewith.

I understand that I have a continuing duty to immediately supplement this questionnaire in writing with any new or additional information obtained.

Dated this _____ day of _____, 20___,

_____ _____
Witness Signature of Participant

_____ _____
Witness Printed name of Participant

STATE OF FLORIDA
COUNTY OF _____

SWORN TO (or AFFIRMED) AND SUBSCRIBED before me this ____ day of

_____, 20___, by _____ *(Participant)* who is:
[ ] Personally known to me **- *OR* -** who [ ] produced the following identification:

_____
Specify type of identification produced

_____ _____
Signature of Notary ***Print, type or stamp name of Notary in addition to seal***