Town of Jupiter Police Officers' Retirement Fund
APPLICATION FOR DISABILITY RETIREMENT

To: Board of Trustees
Town of Jupiter Police
Officers' Retirement Fund

From: Applicant: _____
Address: _____
_____
_____
(Do not use post office box)

Job Title: _____ Employment Date: _____
Home Telephone: _____

DOB: _____ SSN#: _____ Married: Yes __ No __ Date of Marriage: _____

Name of Spouse/Beneficiary: _____ DOB: _____ SSN#: _____
Address of Spouse/Beneficiary: _____

I hereby apply for disability retirement as provided by the Town of Jupiter Police Officers' Retirement Fund Code. I claim this disability to be: □ Service-incurred □ Non-Service-incurred

Doctors' diagnosis: _____

Cause of disability: _____
_____

Accident date: _____ Location: _____

How does the claimed disability affect your work? _____
_____

Did you request the Town of Jupiter and/or the Police Department to make a reasonable accommodation (under the Americans with Disabilities Act) to your claimed disability? □ Yes □ No If yes, please attach a copy of your written request and the Town's response. If no, please attach an explanation of why you did not request such an accommodation.

List below (or attach a separate sheet) the Name, Address (street, city, state, zip) and Telephone Number (including area code) of your family/primary physician and **ALL** doctors, facilities or hospitals who have treated you for the above condition.

_____
_____
_____
_____

I hereby consent, on behalf of myself and any other person entitled to receive monies or benefits by virtue of this application and any resultant pension to investigations (or any nature, type, manner or means) of matters which would in any way bear upon the obligation of the Board of Trustees to pay or continue to pay monies or benefits on account of this application and any resultant pension, at any time and from time to time, without further consent by or notice to anyone including myself, whether conducted by the Board of Trustees or on its behalf, and regardless of whether or not such investigations and/or the reports or results thereof are within the scope of the Fair Credit Reporting Act and/or any other federal, state or local law.

_____ _____
Signature of Applicant Signature of Witness
Date: _____ Date: _____

INCOMPLETE FORMS WILL BE RETURNED TO APPLICANT FOR COMPLETION
(Medical Release and Waiver of Confidentiality Forms must accompany this Application)

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 and the Town of Jupiter, Florida.

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	**Town of Jupiter Police Officers' Retirement Fund** c/o Sugarman Susskind Braswell & Herrera, P.A.
Address of Client	150 Alhambra Circle, Suite 725 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 **Town of Jupiter Police Officers' Retirement 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 eight (8) 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

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 Town of Jupiter 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 Town of Jupiter 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 Town of Jupiter in any way related to any other injury, disease, condition or disability? If yes, please 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:_____

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