

**CITY OF OKEECHOBEE MUNICIPAL FIREFIGHTERS' PENSION FUND**

**APPLICATION FOR DISABILITY RETIREMENT**

THE UNDERSIGNED MEMBER OF THE SYSTEM HEREBY APPLIES FOR DISABILITY RETIREMENT FROM THE CITY OF OKEECHOBEE MUNICIPAL FIREFIGHTERS' PENSION FUND.

NAME: \_\_\_\_\_ TEL. NO. \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

DATE OF EMPLOYMENT: \_\_\_\_\_ JOB TITLE \_\_\_\_\_

DATE OF INJURY OR ONSET OF ILLNESS: \_\_\_\_\_

SPECIFY WHETHER OR NOT INCURRED IN THE PERFORMANCE OF YOUR DUTIES AS A FIREFIGHTER. ☐ In-Line ☐ Not-in-Line

DESCRIPTION OF ACCIDENT, ILLNESS OR INJURY GIVING RISE TO DISABILITY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CURRENT EMPLOYMENT STATUS:

☐ Active

☐ Leave of Absence

☐ Terminated

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

WORKERS COMPENSATION: ☐ Yes ☐ No Date: \_\_\_\_\_

**\*\*\* A PHYSICIAN'S STATEMENT DESCRIBING YOUR PERMANENT DISABILITY AND SPECIFICALLY INDICATING THAT YOU ARE TOTALLY AND PERMANENTLY DISABLED TO THE EXTENT THAT YOU ARE UNABLE TO RENDER USEFUL AND EFFICIENT SERVICE AS A FIREFIGHTER MUST BE SUBMITTED WITH THIS APPLICATION.\*\*\***

**ELIGIBILITY FOR DISABILITY BENEFITS**

Subject to (4) below, you must be an active member of the plan on the date the Board determines your entitlement to a disability benefit.

- (1) Terminated persons, either vested or non-vested, are not eligible for disability benefits.
- (2) If you voluntarily terminate your employment either before or after filing an application for disability benefits, you are not eligible for disability benefits.

- (3) If you are terminated by the City for any reason other than for medical reasons, either before or after you file an application for disability benefits, you are not eligible for disability benefits.
- (4) The only exception to (1) above is:
  - (a) If you are terminated by the City for medical reasons and you have already applied for disability benefits before the medical termination, or;
  - (b) If you are terminated by the City for medical reasons and you apply within 30 days after your medical termination date.

If either (4)(a), or (4)(b) above applies, your application will be processed and fully considered by the board.

---

**WAIVER OF RIGHT TO PRIVACY AND AUTHORIZATION  
FOR PUBLIC DISCLOSURE OF MEDICAL RECORDS**

By requesting disability benefits from the City of Okeechobee Municipal Firefighters' Pension Fund, I understand and acknowledge that my medical, physical, psychological or psychiatric condition must be discussed by the Board of Trustees and the amount of my personal account activities and potential benefit levels within the Fund must also be discussed by the Board.

By applying for the disability benefits and the signing of this waiver and authorization, I hereby waive any right to privacy to all medical records, medical claims records and all other information required to be disclosed to or discussed by the Board of Trustees for the evaluation and determination of my claim and authorize all of such being disclosed as public records.

**I, THE UNDERSIGNED APPLICANT FOR DISABILITY BENEFITS FROM THE CITY OF OKEECHOBEE MUNICIPAL FIREFIGHTERS' PENSION FUND, HEREBY CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

\_\_\_\_\_  
Member's Signature

\_\_\_\_\_  
Date