

**CITY OF OKEECHOBEE GENERAL
EMPLOYEES' RETIREMENT SYSTEM**

**AFFIDAVIT OF DISABILITY BENEFIT RECIPIENT
(Not to be used with Application for Disability Retirement)**

Before me, the undersigned authority, personally appeared _____
_____, who being duly sworn deposes and says:

1. I am currently receiving disability retirement benefits from the City of Okeechobee General Employees' Retirement System.

2. In the immediately preceding calendar year, I received income from the following sources:

- | | | | |
|----|----------------------------------|---------|--------|
| a. | Workers' Compensation. | Yes [] | No [] |
| b. | Any employer. | Yes [] | No [] |
| c. | Self-employment. | Yes [] | No [] |
| d. | Other earned income. | Yes [] | No [] |
| | If yes, please state the source. | | |

3. My current employment involves the following physical activities:

4. The current status of the condition upon which my disability benefits are based and my limitations resulting from such condition are as follows:

5. I engage in the following sports and recreational activities:

6. Attached is my treating physician's report specifically and completely stating:
- a. The status of the condition upon which my disability benefits are based.
 - b. That I remain totally and permanently disabled and unable to perform the duties I was assigned at the time of my impairment or another position at a similar rank and pay, and the reasons therefor.
 - c. The restrictions and limitations resulting from such condition.

7. Attached is additional information that I deem relevant for the Board's consideration in reviewing my continued benefit entitlement. ____ yes ____ no

8. I authorize the Board to utilize this affidavit and any attachments in any public meetings it may have regarding my disability status. I further waive any statutory or common law right of privacy I may have in these records, if necessary to enable the Board to discuss these records in any public meetings in connection with my disability status.

Signature

STATE OF _____
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me by means of ☐ physical presence or
☐ online notarization, this ____ day of _____, 20____ by _____.

Notary Public

Name typed, printed or stamped

My Commission Expires: _____

Personally known _____ OR Produced Identification _____
Type of Identification Produced: _____

* **This form is to be completed only by those persons currently receiving disability benefits.**