CITY OF OKEECHOBEE GENERAL EMPLOYEES' RETIREMENT SYSTEM

APPLICATION FOR DISABILITY RETIREMENT

THE UNDERSIGNED MEMBER OF THE SYSTEM HEREBY APPLIES FOR DISABILITY RETIREMENT FROM THE CITY OF OKEECHOBEE GENERAL EMPLOYEES' RETIREMENT SYSTEM.

NAME: _____ TEL. NO. _____

ADDRESS: _____

_____

DATE OF BIRTH: _____ E-MAIL ADDRESS: _____

DATE OF EMPLOYMENT: _____ JOB TITLE: _____

DATE OF INJURY OR ONSET OF ILLNESS: _____

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 PERFORM THE DUTIES YOU WERE ASSIGNED AT THE TIME OF YOUR IMPAIRMENT OR ANOTHER POSITION AT A SIMILAR RANK AND PAY, 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 General Employees' Retirement System, 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 GENERAL EMPLOYEES' RETIREMENT SYSTEM, HEREBY CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ _____

Member's Signature Date