PALM BEACH GARDENS POLICE PENSION FUND
APPLICATION FOR DISABILITY BENEFITS

PLEASE PRINT OR TYPE

1. a. Name of Employee:_____
(Last) (First) (MI)

b. Social Security Number:_____

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

d. Home Telephone Number: _____
(Area Code) Number

e. Home Address:_____
Address Street

_____
City, State Zip Code

f. Permanent address to which check and/or correspondence should be sent:

_____
Address Street

_____
City, State Zip Code

2. a. Are you currently married: Yes_____ No_____

If yes, please complete the following:

I. Name of Spouse:_____
(Last) (First) (MI)

ii. Spouse's Social Security Number:_____

iii. Spouse's Date of Birth:_____ (Attach proof)
Month-Day-Year

iv. Date of Marriage:_____ (Attach proof)
Month-Day-Year

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

Name	Date of Birth
_____	_____
_____	_____
_____	_____

(Attached additional page if needed)

4. Names of Your Living Parents:

a. Mother:_____

b. Father:_____

5. a. Date of Hire by City of Palm Beach Gardens as
_____

_____:_____
Month-Day-Year

b. Current Position in :_____

6. I plan to retire on:_____
Month-Day-Year

7. Type of retirement for which you are applying (check one):

_____ Normal Retirement
_____ 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:_____
Month-Day-Year

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 City of Palm Beach Gardens terminated?	_____	_____
(5) While working for anyone other than City of Palm Beach Gardens and arising out of such employment?	_____	_____
d. A copy of my doctor's medical opinion is attached:	_____	_____

9. Please provide a list of the doctors you have seen for this or any related condition.

_____

NOTE: *If you are applying for a disability benefit, records must be filed to show that the disability is total and permanent, including a narrative explanation of the current accident. If application is made for a line-of-duty disability, copies of workers' compensation records, including the initial treatment documents, and the pre-employment physical 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.*

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 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.

I hereby waive my right of confidentiality of my medical records an 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 Palm Beach Gardens Police Pension Fund in making available to the Board, or authorized agents of the Board, information which reasonably relates to the initial payment of benefits from the Fund.

I hereby agree to indemnify and hold harmless the City of Palm Beach Gardens and 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 City of Palm Beach Gardens' release of the results of the undersigned's annual physical to the Pension Plan and from and against any resulting losses, costs, expenses, reasonable attorney's fees, liabilities, damages, orders, judgments, or decrees in connection herewith.

Dated this ____ day of _____, 20____.

_____ _____
Witness Printed Name of Participant

_____ _____
Witness Signature of Participant

STATE OF FLORIDA
COUNTY OF _____

Sworn to (or affirmed) before me and subscribed by this _____ day of _____, 20____ by _____.

___ Personally known **-OR-**

___ Produced identification

Type of identification produced: _____

_____
Notary Public, State of Florida At Large

[Notary Seal]