Clear Form

OkMRF OKLAHOMA MUNICIPAL RETIREMENT FUND

Oklahoma Municipal Retirement Fund

APPLICATION FOR DISABILITY STATUS FORM

PARTICIPANT INFORMATION (please print clearly using black or blue ink)

NAME: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE: _____ HOME PHONE: _____

E-MAIL: _____

EMPLOYER NAME: _____ DATE OF BIRTH: _____/_____/_____

INSTRUCTIONS

- Use this form to apply for Disability Retirement status. Submit the completed Authorization for Access to Patient information (page 3) and Physician's Certification of Disability (page 4) along with a copy of the this application to your Employer.
- Once your application has been approved, a copy of the Application for Disability Retirement (page 2) needs to be returned to OkMRF. (Fax #405-606-7879)
- OkMRF will update your status to disabled. Once this status has been recorded at Voya, you will need to access your account to request a distribution.

THIS FORM DOES NOT PROCESS A DISTRIBUTION

DISABILITY INFORMATION (please print clearly using black or blue ink)

NATURE/CAUSE OF DISABILITY: _____

TYPE OF DISABILITY: ☐ INJURY DATE INJURY OCCURRED: _____/_____/_____

☐ ILLNESS DATE WHEN SYMPTOMS FIRST OBSERVED: _____/_____/_____

PRIOR DISABILITY FROM ILLNESS ☐ NO ☐ YES LENGTH OF DISABILITY: _____ DATE: _____/_____/_____

DOES INJURY/ILLNESS PREVENT YOU FROM ENGAGING IN ANY GAINFUL EMPLOYMENT? ☐ NO ☐ YES

IF NO, WHAT TYPE OF WORK COULD YOU DO? _____

LIST ALL LICENSED AND PRACTICING PHYSICIANS SEEN FOR DISABILITY

NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PARTICIPANT CERTIFICATION

In accordance with the provisions of the Retirement Plan, I hereby apply for a Disability Retirement, for which I believe I have met the eligibility requirements. I submit the following information and hereby certify that it is true and correct to the best of my knowledge and belief.

I CERTIFY THAT:

(a) I am less than 65 years of age;

(b) I am unable to perform duties of any assigned position in the municipality that employs me; and

(c) I have not concealed any material fact.

RELEASE OF INFORMATION:

I hereby authorize any doctor, practitioner, hospital or sanitarium to give the Retirement Committee any information if requested about me with reference to any treatments, advice or hospitalization and I agree to execute the appropriate release forms for my medical records.

PARTICIPANT SIGNATURE: _____ **DATE:** _____

SOCIAL SECURITY NUMBER: _____ **EMPLOYER NAME:**_____

FOR EMPLOYER USE ONLY

EMPLOYER CERTIFICATION/APPROVAL

A. I certify that the information as provided is true and correct and that the proper evidence for Proof of Age has been submitted;
B. The Application for Total and Permanent Disability Retirement has been submitted to the Retirement Committee (governing body); and
C. Based on review and action by the Retirement Committee, the employee named herein has been APPROVED for a Total and Permanent Disability Retirement under the terms of the Plan.

AUTHORIZED AGENT FOR THE RETIREMENT COMMITTEE:_____

DATE: _____

PARTICIPANT IS DENIED DISABILITY STATUS

Based on review and action by the Retirement Committee, the employee named herein does not qualify for a Total and Permanent Disability Retirement under the terms of the Plan and the Application for Total and Permanent Disability Retirement is DENIED.

AUTHORIZED AGENT FOR THE RETIREMENT COMMITTEE:_____

DATE: _____

AUTHORIZATION FOR ACCESS BY PATIENT (please print clearly using black or blue ink)

NAME: _____ **SOCIAL SECURITY #:** _____

DATE OF BIRTH: _____/_____/_____

I hereby authorize the use or disclosure of the Protected Health Information (PHI) described below to be provided to or obtained by the following:

NAME & ADDRESS OF EMPLOYER TO RECEIVE PROTECTED HEALTHCARE INFORMATION:

EMPLOYER NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** OK **ZIP CODE:** _____

NAME & ADDRESS OF INDIVIDUAL/FACILITY/COMPANY TO DISCLOSE PROTECTED HEALTHCARE INFORMATION:

NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

Information authorized for use or disclosure, or to be obtained: All medical information concerning this patient

The information will be obtained, used or disclosed for the following purpose(s): Disability Determination

I UNDERSTAND:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following event: _____.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

SIGNATURE (Patient or Legal Representative): _____ **DATE:** _____

DESCRIPTION OF LEGAL REPRESENTATIVE'S AUTHORITY: _____ **DATE:** _____

NOTICE OF RIGHTS: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court of the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

PHYSICIANS CERTIFICATION OF DISABILITY

This is to certify that I have examined the following named claimant and my report covering the nature and extent of his disability is as follows:

NAME OF CLAIMANT: _____ AGE: _____ GENDER: _____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DIAGNOSIS (EXPLAIN IN DETAIL) : _____

_____

_____

1. On what date did illness begin or injury occur? _____
2. When did you first treat the claimant: _____ Where: _____
3. How long prior to your first examination was the illness contracted? _____
4. To what do you attribute origin of illness? _____ Is it chronic? _____
5. Is this illness a primary condition or is it secondary to, complicated with or a sequence of some other illness? _____

_____

6. Has illness or injury necessitated hospitalization? _____ From _____ To _____
7. Has illness or injury necessitated confinement within the house? _____
8. Was the illness or injury of such severity as to disable claimant for the duties of his position? _____
9. Does the illness or injury now prevent any gainful employment by the claimant? _____
   If not, what limitations exist with respect to the type of work he can do? _____
10. How long will claimant be unable to be gainfully employed? _____
11. In your opinion, is this individual totally and permanently disabled so as to be prevented thereby, now and throughout the remainder of his life from engaging in any occupation or employment for remuneration or profits? _____

PHYSICIANS CERTIFICATE OF DISABILITY

I, a practicing physician, duly registered as such under the laws of the State of _____, do hereby certify that my answers to the foregoing questions are true and complete to the best of my knowledge and belief.

PHYSICIANS NAME (PRINTED) : _____ PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHYSICIANS SIGNATURE: _____ DATE: _____

NOTARIZATION OF SIGNATURE

State of: _____ County of: _____

The forgoing document was signed and sworn to (or affirmed) before me on _____(date)
by _____ (name(s) of person(s) making statement).

Signature of Notary: _____ (Seal)

My Commission expires: _____