OKLAHOMA MUNICIPAL RETIREMENT FUND

Clear Form

APPLICATION FOR DISABILITY RETIREMENT PENSION

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

Name _____ Social Security No. _____

Present Address _____
(Number and Street) (City, State, and Zip Code)

Home Phone No. (___)_____ E-mail Address _____

Mobile Phone No. (___)_____ Date of Birth* _____

* **Proper evidence must be submitted to verify age.**

Name of Retirement Plan _____

Names of all other Municipalities through which I retain pension credits in this Fund and dates employed:

1. _____ From _____ To _____
2. _____ From _____ To _____

What is the nature and cause of your disability?

_____

_____

On what date did the injury occur? _____ If the disability is due to an illness, when did you first observe symptoms of the illness? _____

_____

If disability is a result of illness, have you been disabled previously from it? _____

If so, when and how long? _____

List the names and addresses of each licensed and practicing physicians who have examined you in connection with this disability:

1. _____
2. _____

Does the illness or injury now prevent you from engaging in any gainful employment? _____

If not, what type of work could you do? _____

APPLICATION FOR DISABILITY RETIREMENT DISTRIBUTION

I certify that:

(a) I am less than 65 years of age;
(b) I am unable to perform the duties of any assigned position in the municipality that employs me; and
(c) I have not concealed any material fact.

I understand that, in accordance with the Plan:

(1) I shall not qualify for a Disability Pension if the Committee determines that my Disability results from (a) chronic alcoholism, (b) addiction to narcotics, (c) an injury suffered while engaged in a felonious or criminal act or enterprise, or (d) service in the armed forces of the United states which entitles the Employee to a veteran's disability pension; and
(2) My disability shall be considered to have ended and a Disability Pension shall cease if, prior to my Normal Retirement Age, I (a) engage in any substantial gainful employment except for such employment as is found by the Committee to be for the primary purpose of rehabilitation or not incompatible with a finding of total and permanent Disability, or (b) have sufficiently recovered, in the opinion of the Committee based on a medical examination by a doctor or clinic appointed by the Committee to be able to engage in regular employment with the Employer and refuse an offer of employment by the Employer, or (c) refuse to undergo any medical examination requested by the Committee provided that a medical examination shall not be required more frequently than twice in any calendar year.

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.

Date _____ **Participant's Signature** _____

If your plan includes the Defined Contribution Hybrid Option, complete Form DB 4.10 for a Hybrid Account distribution.

AUTHORIZATION FOR ACCESS BY PATIENT OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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:

_____

_____

Name & Address of Individual/Facility/Company to Disclose Protected Healthcare Information:

_____

_____

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.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Description of Legal Representative's Authority

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.

OMRF
OKLAHOMA MUNICIPAL RETIREMENT FUND

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MUNICIPALITY'S CERTIFICATE OF DISABILITY

Name of Employee _____

Name of Plan _____

Date of Disability _____ Last Day Worked _____

1. What were the duties of the position occupied by the Employee when he first was disabled?

   _____

2. To what conditions do you attribute the Employee's disability? _____

   _____

3. Did these conditions exist on the date the Employee was first employed? _____

4. Has Employee, to your knowledge, previously been disabled so as to require medical attention?_____ If so, when and for what condition? _____

   _____

5. Is the Employee's disability such as to prevent the employee from performing the duties of his, or any other, assigned position in your municipality? _____

6. Will the Employee be returned to active duty if and when disability ceases? _____

7. I certify that to the best of my knowledge and belief that above named Employee:
   (a) Has not been separated from the service of this municipality;
   (b) Was in good health upon the first date of participation in the Plan; and
   (c) Is not entitled to any earnings, other than as stated, from this municipality.

I warrant that the foregoing information is true and correct and no material fact has been concealed or omitted.

Signature of Department Head _____

Title _____ Date _____

I certify that this report is executed by an authorized official of this municipality who has complete knowledge of the facts stated.

_____ **BY:** _____

Date **Authorized Agent for the Retirement Committee**

MUNICIPALITY'S CERTIFICATE OF DISABILITY

Employee Name _____

Employment Date _____ Social Security No. _____

Service Credit Date _____ Last Day of Employment _____

Based on the evidence and documentation provided, the Employer submits the following authorization for Disability Retirement Pension:

EMPLOYER CERTIFICATION AND APPROVAL

By signing below, the Authorized Agent confirms that each of the following statements is true and correct:

1. PAYROLL INFORMATION

A. Final salary amount to be submitted or posted on the OMRF data base is as follows:
$ _____, to be paid on _____ (date)

B. I confirm that:
1) I have reviewed the Salary History for this Participant on the OMRF website and confirmed it to be true and accurate; and
2) OMRF is authorized to proceed with the benefit calculation based on this data.

2. CERTIFICATION

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 participant has received a copy of the ***Special Tax Notice*** regarding plan distributions; and
C. The Application for Retirement Pension has been submitted to the Retirement Committee (governing body).

3. APPROVAL BY EMPLOYER FOR PENSION BENEFITS

Based on review and action by the Retirement Committee, the employee named herein has been APPROVED for a Disability Retirement Pension under the terms of the Plan.

_____ **BY:** _____

Date **Authorized Agent for the Retirement Committee**

Participant is Denied Pension Benefits

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

_____ ***BY:*** _____

Date ***Authorized Agent for the Retirement Committee***

PHYSICIAN'S CERTIFICATE 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 _____ City _____ State _____

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? _____

PHYSICIAN'S 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.

_____ Address _____
Signed **Date** City _____
State, Zip _____
_____ Phone _____
Print Name

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).

_____ My commission expires: _____
Signature of Notary

(Seal)

OKLAHOMA MUNICIPAL RETIREMENT FUND

DB 4.33

TAX WITHHOLDING ELECTION
Federal and State Income Tax Withholding

Name _____ Social Security No. _____

COMPLETE SECTION "A" OR "B" BELOW: Name of Plan _____

Section A. RECURRING PAYMENTS – Federal and State Income Tax Withholding

Instructions: As a benefit recipient, the following withholding alternatives are available to you:

- By selecting No. 1 below, you may specify that you do not want any federal or state income tax deducted from your benefit .
- By selecting No 2 below, you may elect the "Allowances Claimed" section and completing the marital status and number of allowances which will require the OkMRF system to determine the amount**, if any**, which must be withheld based on federal and state withholding tables. If elected, the tax withholdings may or may not meet your required amounts.
- By selecting No. 3 below, you may elect to withhold a specified percentage or amount for federal and state income taxes.

In requesting the distribution of my funds from OkMRF, I designate the following withholding election.
This election will remain in effect until I submit another.

1. ☐ I elect **not** to have Federal or State income tax withheld.

2. ☐ I wish to have OkMRF withhold from my monthly benefit the amount of federal and state income tax as determined in accordance with withholding tax tables and the allowances claimed below:
☐ Single ☐ Married ☐ Married –but withhold at higher Single Rate
_____ Number of withholding allowances/exemptions you want to claim.

3. a. ☐ I wish to have _____ (% or $ amount) of Federal income tax withheld.
b. ☐ I wish to have _____ (% or $ amount) of State income tax withheld.

If you do not file a Tax Withholding Election form with OkMRF, we are required by law to assume that you are married and are claiming 3 (three) allowances. We will automatically withhold federal and state income tax if your payment is large enough to require withholdings.

Section B. ONE-TIME PAYMENTS – Federal and State Income Tax Withholding

Instructions: When receiving a total distribution from OkMRF, you may receive the payment in one of two methods:

- The distribution can be made payable to you directly, in which case a mandatory 20% Federal tax withholding and 5% Oklahoma state tax withholding will occur. (The mandatory tax withholding only applies to the taxable portion of your distribution.) **OR**
- You can direct OkMRF to roll over the distribution into an IRA or other qualified plan without taxes being withheld. *You will receive the non-taxable portion of the distribution payable to you even if you direct the taxable portion to a qualified plan or IRA. Rollover checks will be payable to the rollover entity "For the Benefit of" and then your name. All distributions are mailed directly to your address of record.*

In requesting the distribution of my funds from OkMRF, I designate the following method of payment:

1. ☐ **I WANT THE CHECK(S) MADE PAYABLE TO ME**. I am aware of the mandatory 20% Federal and 5% Oklahoma withholding * on the taxable portion of my distribution.
*(Withholding rate is 5% and is subject to change based on Oklahoma State withholding tables.)
If you've made a permanent move into a new state during the tax year, you may have to file two part-year state tax returns. You may wish to consult with a professional tax advisor, before taking a payment from the Plan.

2. ☐ I WANT A DIRECT ROLLOVER TO A **TRADITIONAL IRA.** (YOU MUST SUBMIT A COPY OF YOUR IRA AGREEMENT FOR A DIRECT ROLLOVER.)

3. ☐ I WANT A DIRECT ROLLOVER TO A **QUALIFIED PLAN**. (YOU MUST SUBMIT A COPY A RECENT PARTICIPANT STATEMENT AND THE PLAN'S CONTACT INFORMATION)

I have reviewed the information above and hereby submit this statement of preference regarding how my benefit distribution is to be treated for purposes of federal and state income tax withholding.

_____ _____
Date Participant's Signature

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