Clear Form

OKLAHOMA MUNICIPAL RETIREMENT FUND

Oklahoma Municipal Retirement Fund

APPLICATION FOR DISABILITY RETIREMENT PENSION
DB 4.30

PERSONAL INFORMATION (Please print clearly using black or blue ink)

NAME OF PLAN: *(Employer)* _____

NAME: _____
(First) (Middle) (Last) (Suffix)

SOCIAL SECURITY NUMBER: _____ **DATE OF BIRTH*:** _____ **GENDER:** _____
* Proper evidence must be submitted to verify age

EMPLOYMENT DATE: _____ **SERVICE CREDIT DATE:** _____

PRIMARY PHONE: _____ **EMAIL ADDRESS:** _____

MAILING ADDRESS: _____
(PO Box or Number and Street) (City, State and Zip Code)

PRIOR SERVICE: Have you been employed by another Municipality covered under OkMRF? ☐ No ☐ Yes

If yes, where: _____

INSTRUCTIONS

Use this form to apply for Disability Retirement Pension.
Participant needs to:

1. Complete Personal Information and Sections 1, 2, 3 and 5.
2. Have your Physician complete Section 7.
3. Return Form DB 4.30 to your Employer.

Employer needs to:

1. Complete Section 6.
2. Present Application and physician/municipality evidence to your governing body for consideration.
3. Complete Section 4 to approve or deny Disability Pension.
4. Return pages 1 through 3 ONLY to OkMRF offices and attach a copy of the minutes.
5. Detach pages 4 through 6 and retain for your records.

City to submit pages 1 through 3 to:
VIA MAIL Oklahoma Municipal Retirement Fund
1001 NW 63rd Street, Suite 260
Oklahoma City, OK 73116

Questions? (888) 394-6673, ext. 104 or 109
VIA FAX* Oklahoma Municipal Retirement Fund
(405) 606-7879
* If faxing form please follow-up by sending original via mail.

SECTION 1. DISABILITY INFORMATION

NATURE/CAUSE OF DISABILITY: _____

TYPE OF DISABILITY: ☐ **INJURY** **DATE INJURY OCCURRED:** _____
☐ **ILLNESS** **DATE SYMPTOMS FIRST OBSERVED:** _____

IF ILLNESS, HAVE YOU BEEN PREVIOUSLY DISABLED? _____ **HOW LONG?** _____

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

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

LIST ALL LICENSED AND PRACTICING PHYSICIANS SEEN FOR DISABILITY

NAME: _____

ADDRESS: _____
(Number and Street) (City, State and Zip Code)

NAME: _____

ADDRESS: _____
(Number and Street) (City, State and Zip Code)

Participant to complete

SECTION 2. PARTICIPANT CERTIFICATION

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. **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 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 included the Defined Contribution Hybrid Option, complete Form DB 4.10 for a Hybrid Account Distribution.

SECTION 3. TAX WITHHOLDING ELECTION

RECURRING PAYMENTS – Federal and State Income Tax Withholding

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

OPTION 1: You may specify that you do not want any federal or state income tax deducted from your benefit.

OPTION 2: You may elect the "Allowances Claimed" section and complete 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. You may select to withhold an additional percentage or flat rate in addition to the IRS' tax withholding tables.

In requesting the distribution of my funds from OkMRF, I designate the following election: (check ONE)

OPTION 1 ☐ I elect **not** to have Federal of State income tax withheld

OPTION 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 table and the allowances claimed below:

☐ Single ☐ Married ☐ Married – but withhold at higher single rate

_____ Number of withholding allowances/exemptions you want to claim. *(if blank OkMRF will assume 0)*

Withhold an extra _____% or $_____ State tax Withhold an extra _____% or $_____ Federal tax

If you do not select a Tax Withholding Election by choosing option 1 or 2 above, 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.

Employer to complete

SECTION 4. EMPLOYER CERTIFICATION AND APPROVAL

NAME OF PLAN: _____

NAME OF EMPLOYEE: _____ **SOCIAL SECURITY NO:** _____

HIRE DATE: _____ **SERVICE CREDIT DATE:** _____ **LAST DAY WORKED:** _____

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

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

PAYROLL INFORMATION

A) Final salary amount to be submitted $ _____ , to be paid on _____

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

CERTIFICATION

A) I certify 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 Disability Retirement Pension has been submitted to the Retirement Committee (governing body).

APPROVAL BY EMPLOYER FOR PENSION BENEFITS

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

_____ _____

Date **Authorized Agent for the Retirement Committee**

PARTICIPANT IS DENIED DISABILITY PENSION BENEFITS

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

_____ _____

Date **Authorized Agent for the Retirement Committee**

Page intentionally left blank for two-sided printing.

Participant to complete

SECTION 5. AUTHORIZATION FOR ACCESS BY PATIENT

NAME: _____ **SSN:** _____ **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 HEATHCARE INFORMATION:

EMPLOYER NAME: _____

ADDRESS: _____

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

NAME & ADDRESS OF INDIVIDUAL/FACILITY/COMPANY TO DISCLOSE PROTECTED HEATHCARE 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 PHI 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.

_____ _____

Date **Signature of Patient or Legal Representative**

_____

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 circumstance including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court of 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 Heath or by law.

Employer to complete

SECTION 6. MUNICIPALITY'S CERTIFICATE OF DISABILITY

NAME OF PLAN: _____

NAME OF EMPLOYEE: _____ SOCIAL SECURITY NO: _____

DATE OF DISABILITY: _____ LAST DAY WORKED: _____

What were the duties of the position occupied by the Employee when he/she was first disabled?

_____

_____

_____

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

_____

_____

_____

Did these conditions exist on the date the Employee was first employed? ☐ YES ☐ NO

Has the Employee, to your knowledge, previously been disabled so as to acquire medical attention?

☐ Yes ☐ No If yes, when and for what condition? _____

Is the Employee's disability such as to prevent the employee from performing the duties of his/her, or any other, assigned position in your municipality? ☐ YES ☐ NO

Will the Employee be returned to active duty if and when disability ceases? ☐ YES ☐ NO

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT THE ABOVED NAME 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.

Date	Signature of Department Head	Title

I CERTIFY THAT THIS REPORT IS EXECUTED BY AN AUTHORIZED OFFICIAL OF THIS MUNICIPALITY WHO HAS COMPLETE KNOWLEDGE OF THE FACTS STATED.

Date	Authorized Agent for the Retirement Committee

Physician to complete

SECTION 7. PHYSICIAN'S CERTIFICATE OF DISABLITY

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

NAME OF CLAIMANT: _____ **AGE:** _____ **GENDER:** _____

ADDRESS: _____
(Number and Street) (City, State and Zip Code)

DIAGNOSIS (explain in detail): _____

_____

On what date did illness begin, or injury occur? _____

When did you first treat the claimant? _____ **Where?** _____

How long prior to your first examination did the illness/injury occur? _____

To what do you attribute origin of illness/injury? _____ **Is it chronic?** ☐ **YES** ☐ **NO**

Is this illness/injury a primary condition or is it secondary to, complicated with, or a sequence of some other Illness/injury? ☐ **YES** ☐ **NO**

Has the illness/injury necessitated hospitalization? ☐ **YES** ☐ **NO** **From** _____ **To** _____

Has illness/injury necessitated confinement within the house? ☐ **YES** ☐ **NO**

Was the illness/injury of such severity as to disable claimant for the duties of his/her position? ☐ **YES** ☐ **NO**

Does the illness or injury now prevent any gainful employment by the claimant? ☐ **YES** ☐ **NO**

If no, what limitations exist with respect to the type of work he/she can do? _____

_____

How long will the claimant be unable to be gainfully employed? _____

In your opinion, is this individual totally and permanently disabled so as to be prevented thereby, now and throughout the remainder of his/her life, from engaging in any occupation or employment for remuneration or profits? ☐ **Y** ☐ **N**

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

_____ _____
Date **Signature of Physician**

_____ _____
Phone Number **Print Name**

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

State of: _____ **County of:** _____

The forgoing document was signed and sworn to (or affirmed) before me by _____

On this _____ **Day of** _____ **, 20** _____ **Witness my hand and official seal.**

_____ **My commission expires:** _____
Signature of Notary Public