MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA
7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Disability Retirement Packet

The disability application packet contains the following:

Description of MFPRSI Disability Process: An explanation of the various steps of the disability process.

Questions and Answers: Concerning disabilities and the process.

Required Forms Checklist: A checklist to be used by the individual filing the application.

Instructions for Completing the Disability Retirement Application: Detailed guidance to help complete the application.

Disability Retirement Application: Complete and return to apply for either an Ordinary or Accidental disability.

A copy of each of the required forms is provided for use in filing the application.

If you have any questions, please contact MFPRSI at the address, phone, or email listed in the footer below.

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Description of MFPRSI Disability Process

(Revised July 1, 2024)

1. The member and the chief complete the application and forward it to MFPRSI.

2. MFPRSI responds with a letter/email indicating if the application is complete. If it is not complete, the letter/email indicates each of the items to be completed. If MFPRSI determines that the member has not satisfied any non-medical requirements to apply for a disability retirement, MFPRSI will notify the member of its denial and the basis for the denial.

3. MFPRSI requests medical records from the doctors, clinics, and hospitals listed on the member's application. If the medical records have been included with the application and are in a sealed envelope from the hospital or clinic, MFPRSI will not contact and request information.

4. Typically, the collection of medical records may take three to four weeks, but it may take longer depending upon the responsiveness of the doctors, clinics, and hospitals. When the medical records have been collected and processed, the file is forwarded to MFPRSI's medical board at the University of Iowa Hospitals and Clinics for review.

5. The medical board notifies MFPRSI of the appointment date and time. At that time, the medical board may ask for additional films and test results which may require additional time to acquire. The member's assistance in acquiring the additional materials may be required.

6. A pension officer phones the member to inform them of the appointment date and time. The member is required to keep this appointment unless there are extenuating circumstances.

7. A pension officer mails/emails a letter to the member and the chief informing them of the appointment. The letter includes information concerning where the clinics are located, and what to do when they arrive.

8. After the appointment, the medical board will provide MFPRSI with a summary of their findings. The summary is provided to MFPRSI approximately two weeks following the member's appointment.

9. MFPRSI mails a copy of the medical board findings to the member and the chief.

10. The member and chief then have 10 days to make written comment concerning the medical board findings. The written comment is to address only medical issues associated with the disability.

11. If the member and the chief agree with the medical board's findings, they may jointly or separately mail, email, or fax MFPRSI a waiver of the 10-day comment period.

12. After the 10-day comment period has elapsed, or the date on which the 10-day comment period was waived, MFPRSI's executive director, or designee, decides on the disability. MFPRSI determines if the member is disabled, and if they are disabled, if it is an ordinary or accidental disability.

13. A pension officer informs the member by phone of the decision, and if applicable, contacts the chief to coordinate a date for retirement. MFPRSI also informs the member of the retirement date. A determination letter with the date of retirement or reason for denial is mailed to the member and chief.

14. The member and the city have the right to appeal, in writing, MFPRSI's determination within 30 calendar days of the date of the determination letter. If an appeal is filed, a committee of MFPRSI's Board of Trustees will be appointed to hear the appeal in formal session.

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Questions and Answers

Concerning "Ordinary" and "Accidental" Disability

The Disability Application Process

Q: Can I apply for a disability after I've left employment with the city?
A: No. To be eligible to apply for a disability retirement, you must be a "member in good standing" and still employed by the city at the time of application or receiving an ordinary disability benefit and within 3 years of termination.

Q: What is a "member in good standing"?
A: A "member in good standing" is any member in service who has not been terminated by the employing city pursuant to section 400.18 or 400.19. A member remains in good standing until the member has been terminated and exhausted all appeals available under any applicable collective bargaining agreement or applicable law.

Q: What if I lose my appeals and the termination is upheld?
A: If a member is ultimately determined not to be in good standing, the member has the obligation to return benefits paid in error with interest.

Q: Is the medical information I share with MFPRSI confidential?
A: The medical information provided by the clinics and/or the member will be utilized solely by MFPRSI and its medical board. The findings of the medical board will be shared with you, and the applicable city's departments and its representatives. Documentation of the application process will be maintained by MFPRSI in a confidential disability file for the member. If the disability case results in an appeal, the information is subject to disclosure to all parties to the appeal.

Q: How long does the disability application process take?
A: The application process usually takes approximately 120 days from the date MFPRSI receives a complete application until the disability decision.

Q: What do I need to provide to MFPRSI?
A: Along with the completed disability application, if possible, obtain copies of medical records, X-rays, and MRIs from physicians and clinics you've seen for your disabling condition. The records must be in a sealed, unopened envelope from the hospital/clinic or mailed to MFPRSI directly. MFPRSI will take steps to collect this information if it is not provided with the application. When mailing your application, in anticipation of an award of disability retirement, MFPRSI requires all certificates, tax withholding forms, and a direct deposit form (see Required Forms Checklist on page 6).

Q: Will I have to go to Iowa City to be seen by the medical board?
A: Yes. An evaluation by at least two physicians from our medical board is a required part of the disability application process.

Q: Who makes the determination if I qualify for a disability?
A: The executive director, or designee, makes the decisions on behalf of MFPRSI, subject to consideration of the following:

1. Governing statute (Chapter 411)
2. Judicial decisions interpreting the provisions of the statute.
3. Concurrence of the medical board as stated in their submission of the findings following the examinations.
4. Contents of application and medical records contained therein.

Q: What happens if I am denied a disability retirement?

A: The member will be restored to active service in the same position held immediately prior to the application for disability benefits. The member or the city may appeal the decision within 30 days of its issuance.

Ordinary and Accidental Disability

Q: What is the difference between an accidental and an ordinary disability?

A: An accidental disability is a total and permanent (defined as lasting a year or more) incapacitating disability, which was the result of an injury or disease incurred in or aggravated by the actual performance of duties or arising out of or in the course of employment as defined by statute including heart, lung, cancer, and infectious diseases (see Iowa Code Chapter 411.6(5)(c)((1, 2)).

To establish a mental injury is eligible for an accidental disability, the injury must be traceable to a readily identifiable work event constituting a manifest happening of a sudden traumatic nature from an unexpected cause or unusual strain in the workplace. Whether an event is traumatic, unexpected, or unusual is determined by comparing the incident to the experiences of other police officers or firefighters in Iowa.

An ordinary disability is a permanent (defined as lasting a year or more) incapacitating disability, which does not meet the definition of an accidental disability.

Q: What is the difference between a disability retirement and a service retirement?

A: A member must be age 55 or over and vested to be eligible for a service retirement. No age requirements exist for a disability retirement. Service retirees have a choice of the basic benefit or one of six other benefit options. Disability retirees receive the basic benefit.

Disability Benefits

Q: How much will my benefit payment be?

A: The disability multiplier determines the pension benefit, the member's years of service, and averaged earnable compensation. Your first benefit payment may be estimated until the city reports the final earnable compensation to MFPRSI.

The multipliers for disabilities are:

Years of Service	Ordinary Disability	Accidental Disability
0- less than 5	25%	60%
5-16	50%	60%
17	17/22 X 66% = 51%	60%
18	18/22 X 66% = 54%	60%
19	19/22 X 66% = 57%	60%
20	20/22 X 66% = 60%	60%
21	21/22 X 66% = 63%	63%
22	66%	66%
23	68%	68%
24	70%	70%
25	72%	72%
26	74%	74%
27	76%	76%
28	78%	78%
29	80%	80%
30	82%	82%
More than 30	82%	82%

Q: When do I receive my first benefit payment?

A: Pension payments are made on the last business day of each month. Your monthly benefit payment will be direct deposited into your bank account on that day. If your disability retirement date is near the end of the month, your first benefit payment may be received at the end of the following month. If that happens, the first payment will include payment for both months. The date the original decision is made is the date that benefits will begin.

Q: Is a portion of my disability pension taxable?

A: An ordinary disability pension is 100% taxable. The portion of an accidental disability pension that is greater than the basic 60% formula will be reported to the IRS and the State of Iowa as taxable income. An IRS private letter ruling stated that the portion of the benefit that exceeds the accidental disability benefit formula (greater than 60%) is taxable.

Q: Who is my beneficiary?

A: The beneficiary for a disability retirement benefit is the member's spouse. If the retiree predeceases their spouse, the surviving spouse will receive an amount equal to 50% of the gross monthly benefit received by the member.

Q: May I work while receiving my disability pension?

A: A member may hold gainful employment after a disability retirement. Iowa Code 411.6 (7)(a) requires disability retirees to annually submit to MFPRSI a complete copy of their federal and/or State of Iowa income tax report for each year in which they are working until they are age 55. MFPRSI is required by statute to review the reports and shall reduce the member's monthly disability allowance if the member's earnings exceed the annual limit.

Note: Public Safety Occupation Restriction

Iowa Code section 411.6(7)(c) provides that a disability benefit paid to an individual under age 55 will be discontinued if that individual is employed in a public safety occupation within Iowa. Public safety occupations include the following:

- Peace officer as defined in section 97A.1 (POR).
- Sheriff or deputy sheriff as defined in section 97B.49C (IPERS).
- Police officer or firefighter as defined in section 411.1 of the Iowa Code who was not restored to active service under section 411.6(7).
- Protection occupation as defined under section 97B.49B (IPERS).

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7155 Lake Drive, Suite 201
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Required Forms Checklist

Forms for steps A, C, and D can be found on our website, www.mfprsi.org, and are required at the time of application for disability retirement. The certificates required in step B are provided by you, the applicant. It is advised to use the following checklist to help you submit all the materials needed for the disability application process. If you have any questions, please contact MFPRSI.

☐ **A. Disability application is complete:**

a. All required sections are signed by the chief, member, and spouse.
b. The "Reason for inability to perform duties" is completed. Identify each injury or illness which may make you unable to perform your duties.
c. All medical records are included from the member's personnel file.
d. The current job description of the member's position is included.
e. The address and phone number of each physician/clinic/hospital listed is complete.
f. Both sections of the Information Release are signed and dated.

☐ **B. All certificates are included (legible photocopies are acceptable, please do not send originals):**

a. Member's state-issued birth certificate.
b. Spouse's state-issued birth certificate.
c. Marriage certificate.
d. If the spouse was married previously, a copy of the first and signature pages of the divorce decree or the death certificate, whichever is applicable.
e. If the member was married previously, a copy of the member's divorce decree and stipulation, or marital property order, that indicates if the member's pension was divided.

☐ **C. Tax withholding forms are complete:**

a. Federal W4-P Withholding form: The lower portion of the first page of the withholding form is completed. The upper portion of the first page is a worksheet for your use and need not be filled in. If you are choosing to withhold, make sure you have chosen a "marital status" and indicated the number of allowances in number "2." The number of allowances goes on the small line on the right side of the document. Line #3 is only for additional tax withholding beyond what the "marital status" and "allowances" calculate. Remember to sign and date the form.

   Note: The Internal Revenue Service does not allow you to withhold a flat dollar amount. Do not use line #3 for this purpose.

b. State of Iowa W4-P Withholding form (optional): If you choose to withhold, the lower portion of the withholding form is completed. Remember to sign and date the form.

☐ **D. Direct deposit form is complete:**

a. Remember to attach a voided check to the Direct Deposit form. MFPRSI cannot split your deposit into multiple accounts. If you do not have checks for your account, attach a letter from your bank that gives the bank's routing number and your account number. Remember to sign and date the form.

MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA
7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Instructions for Completing the Disability Retirement Application

To the member:
Please complete the application then give the application to your employer for completion of their sections.

Please note: When the member is initiating the application, the employer must complete Parts II-A 4, II-B, II-C, and II-D. When the chief is initiating the application, the member must complete and sign Parts II-A 4, III and IV.

Either you or your employer may submit the completed form to MFPRSI. It is suggested, however, that you retain a photocopy for your files.

If, because of medical reasons, you are unable to complete the application, you may execute a power of attorney appointing someone to act on your behalf. Please send a copy of the power of attorney to MFPRSI along with the completed application.

Confidentiality: Please be aware that the specifics of your disability application cannot be discussed with you by MFPRSI's pension officers. All details of your situation must be submitted in writing to be considered by the medical board and MFPRSI.

To the employer:
The employer is required to complete the following sections of the application regardless of whether the member or the chief is filing the application: Parts II-A 4, II-B, II-C, and II-D.

Either the chief or the member may submit the application to MFPRSI, but it is suggested that the city retain a photocopy for its files. Please note these records must be maintained as confidential and retained in a secure environment.

Important Notice: Member in Good Standing
Iowa Code sections 411.6(3) and 411.6(5) provide that only a "member in good standing" is eligible for a disability retirement. A "member in good standing" means any member in service who has not been terminated by the employing city of the member pursuant to section 400.18 or 400.19. Termination procedures initiated by the chief of police or chief of the fire department pursuant to section 400.19 shall not become final or adversely impact a member's status as a member in good standing until all appeals provided by an applicable collective bargaining agreement or by law have been exhausted. Disciplinary action other than discharge shall not adversely affect a member's status as a member in good standing. See Iowa Code section 411.1(14).

If a member is not a "member in good standing" after all appeals have been exhausted, disability benefits will terminate, and the member will be required to return all disability benefits received plus interest to MFPRSI.

Important Notice: Public Safety Occupations
Iowa Code section 411.6(7)(c) provides that a disability benefit paid to an individual under age 55 will be discontinued if that individual is employed in a public safety occupation within Iowa. Public safety occupations include the following:

- Peace officer as defined in section 97A.1 (POR).
- Sheriff or deputy sheriff as defined in section 97B.49C (IPERS).
- Police officer or firefighter as defined in section 411.1 of the Iowa Code who was not restored to active service under section 411.6(7).
- Protection occupation as defined under section 97B.49B (IPERS).

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7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Disability Retirement Application

This is an application for disability retirement with MFPRSI. The governing statute provides for two types of disability retirement:

Ordinary Disability: A disability resulting in an incapacity to perform assigned duties which is expected to be permanent.

Accidental Disability: A total and permanent incapacity from duty as the result of an injury or disease incurred in or aggravated by the actual performance of duties, or arising out of or in the course of the employment, as defined by statute including heart, lung, cancer, and infectious diseases (see Iowa Code Chapter 411.6 (5)(c)(1, 2)). The existence of one of these conditions does not automatically lead to a determination of disability.

To establish a mental injury is eligible for an accidental disability, the injury must be traceable to a readily identifiable work event constituting a manifest happening of a sudden traumatic nature from an unexpected cause or unusual strain in the workplace. Whether an event is traumatic, unexpected, or unusual is determined by comparing the incident to the experiences of other police officers or firefighters in Iowa.

Please note – Determination of ordinary or accidental rests with MFPRSI.

Part I - Member Information

First Name _____ Last Name _____ Last 5 digits of SSN _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____

Email _____ Phone _____

1. **Have you, the member, been divorced?**
   If "yes," please attach a copy of the divorce decree and stipulation.
   Yes ☐ **No** ☐
2. Are there additional court documents that pertain to a division of benefits?
   If "yes," attach a copy.
   Yes ☐ No ☐
3. Are you, the member, currently receiving payments made under the provisions of either workers' compensation or unemployment compensation for your disability?
   Yes ☐ No ☐
4. Are you, the member, currently a "member in good standing" according to the definition provided within this application packet?
   Yes ☐ No ☐

MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA
7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Disability Retirement Application

Part II-A: Disability Application

1. Application Statement

The member applying for disability retirement or the chief applying for disability on behalf of the member may complete this section, but not both.

To be completed by the member:

I, (print name) _____ (First Name) _____ (Last Name), hereby apply for disability retirement under the provisions of Chapter 411 of the Iowa Code.

To be completed by the chief of the department as application for disability retirement on behalf of the member. The chief does not need to print his or her name if the member is filing a disability retirement application.

I, (print name) _____ (First Name) _____ (Last Name), hereby apply for disability retirement under the provisions of Chapter 411 of the Iowa Code on behalf of the employee.

2. Type of Disability

Whomever completed Part II-A question 1 above must also complete questions 2-4 below of Part II-A.

Please indicate which type of disability you believe is applicable. The final determination concerning which is appropriate is a decision that is made by MFPRSI.

☐ Ordinary Disability — A disability resulting in an incapacity to perform assigned duties which is expected to be permanent.

☐ Accidental Disability — A total and permanent incapacity for duty as the result of an injury or disease incurred in or aggravated by the actual performance of duties (includes heart and lung disease, certain cancers, and infectious diseases).

Important Notice: Mental Injuries

To establish that a mental incapacity (e.g., post-traumatic stress disorder, or "PTSD") occurred as the natural and proximate result of an injury or disease incurred in or aggravated by the actual performance of duty or arising out of and in the course of the employment, or while acting, pursuant to order, outside of the city by which the member is regularly employed, the member must demonstrate that the mental incapacity is traceable to a readily identifiable work event constituting a manifest happening of a sudden traumatic nature from an unexpected cause or unusual strain in the workplace. Whether an incident is traumatic, unexpected, or unusual is determined by comparing the incident, and not the effect on the member, to the experiences of other police officers or firefighters in Iowa. A member must be able to trace their mental injury to a specific event or events in the work (see Iowa Code Chapter 411.6 (5)(*0d*).

MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA
7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Disability Retirement Application

3. Reason for inability to perform duties.
Please identify the condition(s) or disease(s) and the causation(s) for each ***condition(s) or disease(s).***:

EXAMPLES	
Condition/Disease	Causation
Injured right knee	Injured while climbing a ladder fighting a fire on MM/DD/YYYY at 123 Street, City, IA, Zip
Heart disease	411 heart presumption

Condition/Disease	Causation
_____	_____ _____
_____	_____ _____
_____	_____ _____
_____	_____ _____

MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA
7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Disability Retirement Application

4. Certification of Execution

These statements are to be signed and dated by the designated persons.

Member: I hereby certify that I have listed all the physicians, hospitals, and clinics that have treated me for my disabling injury or illness. I further certify that I have included with this application all information available on my condition to the date of this application.

Member's Signature _____ Date _____

Check this box if you are **NOT** married: ☐

Spouse: I hereby acknowledge that the information listed by the above member is true to the best of my knowledge. I further acknowledge that benefits payable to the member will cease upon the member's death and it is my responsibility to report the death to MFPRSI immediately and return said payments if I receive them.

Spouse's Signature _____ Date _____

Chief: I hereby certify that I have included all relevant information on the member's injury or illness available from his/her personnel files, and have made any comment concerning this application in the space provided in Part II–D of this application.

☐ 1. I hereby certify that all applicable records from the city's files (i.e., medical records including workers' compensation medical records – **EXCLUDING** invoices relating to workers' compensation claims, personnel records, disciplinary records, fire investigation report, etc.) have been included with this application OR have been mailed separately to MFPRSI.

☐ 2. I hereby certify that the applicant is a "member in good standing" according to the definition provided within this application packet.

OR

☐ I hereby certify that the applicant is NOT a "member in good standing" according to the definition provided within this application packet (please explain within Part II-D).

If the member is NOT a "member in good standing", have all appeals provided by an applicable collective bargaining agreement or by law been exhausted?

☐ Yes, all appeals have been exhausted

☐ No, there are outstanding appeals regarding the member's termination.

Chief's Signature _____ Date _____

MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA
7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Disability Retirement Application

Part II-B: Employer's Statement of Applicant's Disability

To be completed by the employer:

Employer: _____
Name of City

_____ _____
Email Phone

1. Member's Date of Hire: _____ Current rank: _____

2. Is the applicant identified on Part I currently on temporary disability? Yes ☐ No ☐

3. If "yes," please give the date on which this applicant was placed on temporary disability: ____ / ____ / ____
MM DD YYYY

4. Last working day on the job: ____ / ____ / ____
MM DD YYYY

5. Is the applicant currently receiving any type of compensation from the city? Yes ☐ No ☐

6. If "yes," list the type(s) of compensation being paid to the applicant including sick leave and other types of compensation (do not include vacation pay):

7. If this application is for accidental disability, was the injury documented with the department? Yes ☐ No ☐

8. Copies of all available records which relate to the applicant's disability (including medical records, accident reports, and the temporary disability file, if any, but **EXCLUDING** invoices relating to workers' compensation claims) must be furnished to MFPRSI along with this application. Please check one of the following and complete as necessary:

☐ Employer has no records relating to the applicant's disability.

☐ Copies of the following records are enclosed (please list or include a printout of the items enclosed):

Important Notice: Accidental Disability

Iowa law requires that an applicant seeking accidental disability due to an injury be able to connect the disabling injury or disease to the actual performance of duty. If the applicant is applying for an accidental disability retirement due to an injury, please provide all documentation addressing whether the injury was incurred or aggravated by the performance of duty. Any workers' compensation materials (excluding invoices relating to any workers' compensation claims) should be included in the documentation of the injury.

MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA
7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Disability Retirement Application

Part II-C: Assigned Duties

Please describe below (or attach a description of) the assigned duties of the applicant identified in Part I. The statement of assigned duties should pertain to the applicant's current position.

☐ Job description is attached.

☐ Job description is **NOT** attached. Describe assigned duties in the space below.

Part II-D: Employer Disability/Injury Report and Comment

Please make any additional comments pertaining to the individual's application, including information concerning relevant personnel and disciplinary records or incidents not documented with the department. Attach additional pages as necessary.

☐ I have no response or comment on this application (to be completed by the chief).

Response:

MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA
7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Disability Retirement Application

Part III: Information about Your Medical Records

Please print, type, or write clearly and answer all items to the best of your ability. If you are filing on behalf of someone else, enter his/her name and social security number in the space provided and answer all questions. Complete answers will aid in processing the application.

Member Information:

First Name _____ Last Name _____ Last 5 digits of SSN _____

1. List the name, address, and telephone number of the **doctor** who has the latest medical records about your disabling condition. If you have **no** doctor, check: ☐

Doctor's Name _____ Clinic _____

Street Address _____ City _____ State _____ Zip _____

Doctor's Email _____ Doctor's Phone _____ Doctor's Fax _____

How often do you see this doctor? _____

Date you **first** saw this doctor: _____ Date you **last** saw this doctor: _____

Were x-rays taken? Yes ☐ No ☐ Were MRIs taken? Yes ☐ No ☐

Reasons for visits (show illness or injury for which you had an examination or treatment):

_____

Type of treatment or medicines received (e.g., surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known). If no treatment or medicines, write "NONE".

_____

2. If you have seen other **doctors** since your disabling condition began, please include the following:

Doctor's Name _____ Clinic _____

Street Address _____ City _____ State _____ Zip _____

Doctor's Email _____ Doctor's Phone _____ Doctor's Fax _____

How often do you see this doctor? _____

Date you **first** saw this doctor: _____ Date you **last** saw this doctor: _____

Were x-rays taken? Yes ☐ No ☐ Were MRIs taken? Yes ☐ No ☐

Reasons for visits (show illness or injury for which you had an examination or treatment):

_____

Type of treatment or medicines received (e.g., surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known). If no treatment or medicines, write "NONE".

_____

MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA
7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Disability Retirement Application

3. Identify any other **doctors** you have seen since your illness or injury began:

Doctor's Name _____ Clinic _____

Street Address _____ City _____ State _____ Zip _____

Doctor's Email _____ Doctor's Phone _____ Doctor's Fax _____

How often do you see this doctor? _____

Date you **first** saw this doctor: _____ Date you **last** saw this doctor: _____

Were x-rays taken? Yes ☐ No ☐ Were MRIs taken? Yes ☐ No ☐

Reasons for visits (show illness or injury for which you had an examination or treatment):

_____

Type of treatment or medicines received (e.g., surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known). If no treatment or medicines, write "NONE".

_____

4. Have you been **hospitalized or treated at a clinic** for your disabling condition? Yes ☐ No ☐
If "yes," provide the following information:

Name of Hospital or Clinic _____

Street Address _____ City _____ State _____ Zip _____

Hospital Phone _____ Hospital Fax _____ Patient or Clinic Number _____

Were you an inpatient (i.e., stayed overnight?) Yes ☐ No ☐
If "**yes**," provide the following information:

Were x-rays taken? Yes ☐ No ☐ Were MRIs taken? Yes ☐ No ☐

Date(s) of Admission(s): _____

Date(s) of Discharge(s): _____

Were you an outpatient? Yes ☐ No ☐
If "**yes**," provide the following information: Date(s) of Visit(s): _____
Were x-rays taken? Yes ☐ No ☐
Were MRIs taken? Yes ☐ No ☐

Reasons for hospitalizations/clinic visits (show illness or injury for which you had an examination or treatment):

_____

Type of treatment or medicines received (e.g., surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known). If no treatment or medicines, write "NONE".

_____

MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA
7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Disability Retirement Application

5. If you have been in other **hospitals or clinics** for your disabling condition, identify below:

Name of Hospital or Clinic

Street Address | City | State | Zip

Hospital Phone | Hospital Fax | Patient or Clinic Number

Were you an inpatient (i.e., stayed overnight?) Yes ☐ No ☐
If "**yes**," provide the following information: Date(s) of Admission(s): _____
Date(s) of Discharge(s): _____

Were you an outpatient? Yes ☐ No ☐
If "**yes**," provide the following information: Date(s) of Visit(s): _____
Were x-rays taken? Yes ☐ No ☐
Were MRIs taken? Yes ☐ No ☐

Reasons for hospitalizations/clinic visits (show illness or injury for which you had an examination or treatment):

Type of treatment or medicines received (e.g., surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known). If no treatment or medicines, write "NONE".

Provide Additional Information, if necessary:

MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA
7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Disability Retirement Application

Part IV: Patient's Authorization for Release of Information

Name of Patient: _____

Maiden or Previous Name(s): _____

Date of Birth: _____ Last 5 Digits of SSN: _____

Part IV-A: Authorization for Release of Individually Identifiable Health Information

I hereby authorize the disclosure of my individually identifiable health information, as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan, health care provider or other entity with privacy obligations under Health Insurance Portability and Accountability Act (HIPAA), the released information may no longer be protected by federal privacy regulations.

Person(s)/organization(s) authorized to release the information (list each hospital, clinic, doctor below. Make additional copies of this page if more space is needed):

Organization receiving the information:
MFPRSI (which shall also include its' Medical Board), 7155 Lake Drive, Suite 201, West Des Moines, IA 50266.

A. Any and all information (to include, but not limited to all applicable medical records, x-rays, MRIs, test results, physician notes, etc.) EXCEPT substance abuse (drug or alcohol), mental health, and AIDS-related information which must be specifically authorized in Section IV-D below to be released;

or instead

☐ B. Only the following information (check box only if applicable):

MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA
7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Disability Retirement Application

Part IV-B: Disclosure

- I understand the information is being disclosed and may be used only in connection with my claim for disability benefits from MFPRSI.
- Iowa and/or Federal law provides that I have a right to prohibit re-disclosure of confidential medical information and further disclosure may not be had without my express written authorization, as indicated below.
- I further understand that MFPRSI, WITHOUT FURTHER AUTHORIZATION, may re-disclose said information to:

☐ A. Parties and their legal counsel, insurers, experts, potential experts, anyone against whom claim is or has been made, administrative agency and court officials hearing the claim, and any agents, employees, or representatives of any of said person;

or instead,

☐ B. Only the following information (check box only if applicable):

I specifically authorize and consent to any said disclosure and re-disclosure.

- Federal and/or State law specifically require that any disclosure or re-disclosure of substance abuse, alcohol or drug abuse, mental health, or AIDS-related information must be accompanied by the following written statement:

  "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." [See also Iowa Code Chapter 228 and Section 141.23(3) and other applicable laws.]

- Iowa Code Section 228.9 provides that psychological test material may be disclosed only to a licensed psychologist designated by the subject of the test. The section further provides that such material may not be disclosed to any other person, including the subject of the test.

Part IV-C: General Authorization

- I understand that I have a right to inspect the disclosed information at any time.
- This Authorization is effective the date it is signed and continues to be effective for up to twelve (12) months past the date of signature. I understand that I may revoke this Authorization in writing at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or record keeper.
- A photocopy or exact reproduction of this signed Authorization shall have the same force and effect as this original.
- I understand that, for the above information to be released, I must sign here, and complete and sign Part IV–D of this form.
- I understand that my refusal to sign this form may result in the denial of my claim for disability benefits from MFPRSI.

Signature of Patient or Legal Guardian _____ Date _____

Street Address _____ City _____ State _____ Zip _____

Relationship, if NOT the patient _____

MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA
7155 Lake Drive, Suite 201
West Des Moines, IA 50266

Disability Retirement Application

Part IV-D: Specific Authorization for Release of Information Protected by State or Federal Law

- I acknowledge that information to be released may include material that is protected by Federal and/or State law applicable to substance abuse, mental health, and/or AIDS-related information.
- I SPECIFICALLY AUTHORIZE the release of confidential information relating to:

Mark "Yes" or "No" on EACH of the following, as applicable:

Please note that answering "No" to the following requests may cause your medical professionals to not release your medical records causing a delay in the collection of medical records and therefore impeding the disability application process.

Yes ☐ No ☐ Substance abuse (drug or alcohol) information from (list names of agencies, facilities, or individuals):

Yes ☐ No ☐ Mental health information from (list names of agencies, facilities, or individuals):

Yes ☐ No ☐ AIDS-related information, diagnosis, and test results from (list names of agencies, facilities, or individuals):

- Furthermore, I **SPECIFICALLY AUTHORIZE** disclosure and re-disclosure of this confidential information to all the persons referred to in **Part IV–B above**.

Signature of Patient or Legal Guardian _____ Date _____

Relationship, if NOT the patient _____