MFPRSI INSTRUCTIONS FOR COMPLETING AN APPLICATION FOR DISABILITY RETIREMENT

TO THE MEMBER:

Please complete the application, then give this form to your employer for completion of their sections. The completed application is then forwarded to the System.

Please note: When the member is initiating the application, the Employer must complete Sections II A-4, II B, II C, and II D. When the Chief is initiating the application, the member must complete and sign Sections 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 the retirement System along with the completed application.

Copies of the following documents need to be submitted to MFPRSI:

- Your Birth Certificate
- Your spouse's Birth Certificate (if married)
- Your Marriage Certificate (if married)
- Your Divorce Decree, Marital Property Order,
- Other Court documents that refer to Chapter 411 benefits
- Your spouse's prior marriage certificate, divorce decree or prior spouse's death certificate (if your spouse was married prior to his/her marriage to you)

Confidentiality: Please be aware that the specifics of your disability application cannot be discussed with you by the Retirement System's Pension Officers. All details of your situation must be submitted in writing to be considered by the Medical Board and the Executive Director.

TO THE EMPLOYER:

The Employer is requested to complete the following sections of the application regardless of whether the member or the Chief is making the application: Sections 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 a member in service who is not subject to removal by the employing city of the member pursuant to section 400.18 or 400.19, or other comparable process, and who is not the subject of an investigation that could lead to such removal. See Iowa Code section 411.1(12).

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)
- Police Officer or Fire Fighter as defined in section 411.1 of the Iowa Code who was not restored to active service under section 411.6(7).
- Sheriff or Deputy Sheriff as defined in section 97B.49C (IPERS)
- Protection Occupation as defined under section 97B.49B.(IPERS)

MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA

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I: GENERAL APPLICANT INFORMATION

This is an application for MFPRSI disability retirement. 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 for duty as the result of an injury or disease incurred in or aggravated by the actual performance of duties as defined by Statute including heart, lung, cancer and infectious diseases[See §411.6 (5) (c) (1, 2)]. The existence of one of these conditions does not automatically lead to a determination of disability.**

Please note: Determination of ordinary or accidental rests with the System

Information about the Member. Please print legibly.

Member's Name: _____

Mailing Address:

Phone Number (home): _____ (work): _____

SSN (last 4 digits) _____ Date of Birth: _____

Email Address: _____

Has there been a divorce decree, or marital property order? Attach a copy. ☐ Yes ☐ No

Other Court documents that include a division of benefits? (Attach a copy.) ☐ Yes ☐ No

Is the member currently receiving any payments made under the provisions of workers' compensation or unemployment compensation for this disability? ☐ Yes ☐ No

Is the member currently a "Member in Good Standing" according to the definition provided on the cover page of this application?? ☐ Yes ☐ No

II – A: DISABILITY APPLICATION

(1) APPLICATION STATEMENT

(<u>One or the other, not both</u>)

To be completed by the member:

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

<u>Or</u> by the Chief:

This part is to be completed <u>only</u> by the chief of the department as application for disability retirement on behalf of a member of the department. **Do not complete this statement if the member is filing his or her own application for disability retirement with MFPRSI.**

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

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(2) TYPE OF DISABILITY: (whomever is completing Section II A-1 above must also complete Sections II A-2, II A-3, and II A-4 below)

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

☐ 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 and certain cancers and infectious diseases).

(3) REASON FOR INABILITY TO PERFORM DUTIES: Please identify the condition(s) and the causation for each condition. (e.g., “coronary artery disease” or “Injured lower back while lifting patient into ambulance”)

(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.**

X

Member's Signature | Date

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 the System immediately and return said payments if I receive them.**

X

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 III – D of this application.**

(1) ☐ **I hereby certify that all applicable records from the City's files (i.e., medical records, personnel records, disciplinary records) have been included with this application OR have been mailed separately to the System.**

(2) ☐ **I hereby certify that the applicant is a "Member in Good Standing" according to the definition provided on the cover page of this application.**

OR

☐ **I hereby certify that the applicant is NOT a "Member in Good Standing" according to the definition provided on the cover page of this application (please explain on attachment).**

X

Chief's Signature | Date

II – B: EMPLOYER'S STATEMENT OF APPLICANT'S DISABILITY

To be completed by the employer:

Employer: _____
(Name of City)

Employer's Email Address: _____

1. Member's Date of Hire: _____ Current rank: _____
2. Is the applicant identified on Part A currently on temporary disability? ☐ Yes ☐ No
3. **If yes**, please give the date on which this applicant was placed on temporary disability.

_____

4. Last working day on the job: _____/_____/_____
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 application is for accidental disability, was injury documented with the department?

_____

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) 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 are enclosed (please print list of items enclosed):

II – C: ASSIGNED DUTIES

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

☐ Job description is attached.

☐ Job description is NOT attached.

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:

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 or her name and social security number in the space provided and answer all questions. Complete answers will aid in processing the application.

MEMBER NAME:		**SSN:(last 4 digits)**

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: ☐

   Name: _____ Clinic: _____

   Address: _____
   Street City State Zip

   Telephone number: _____ Email Address: _____

   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 (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known. If no treatment or medicines, show "NONE")

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

   Name: _____ Clinic: _____

   Address: _____
   Street City State Zip

   Telephone number: _____ Email Address: _____

   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 (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known. If no treatment or medicines, show "NONE")

3. Identify below any other **doctor** you have seen since your illness or injury began.

Name: _____ Clinic: _____

Address: _____
Street City State Zip

Telephone number: _____ Email Address: _____

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 (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known. If no treatment or medicines, show "NONE")

4. Have you been **hospitalized or treated at a clinic** for your disabling condition? ☐ Yes ☐ No

Name of hospital or clinic: _____

Address: _____
Street City State Zip

Telephone number: _____ Patient or clinic number: _____

Were you an inpatient (stayed overnight)? ☐ Yes ☐ No If yes, show:

Were X-Rays taken? ☐ Yes ☐ No Were MRIs taken? ☐ Yes ☐ No

Dates of Admissions: _____

Dates of Discharges: _____

Were you an outpatient? ☐ Yes ☐ No If yes, show:

Dates of visits: _____

Were X-Rays taken? ☐ Yes ☐ No Were MRIs taken? ☐ Yes ☐ No

Reasons for hospitalization/clinic visits (show illness or injury for which you had exam or treatment):

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

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

Name of hospital or clinic: _____

Address: _____
Street City State Zip

Telephone number: _____ Patient or clinic number: _____

Were you an inpatient (stayed overnight)? ☐ Yes ☐ No If yes, show:

Dates of Admissions: _____

Dates of Discharges: _____

Were you an outpatient? ☐ Yes ☐ No If yes, show:

Dates of visits: _____

Were X-Rays taken? ☐ Yes ☐ No Were MRIs taken? ☐ Yes ☐ No

Reasons for hospitalization/clinic visits (show illness or injury for which you had exam or treatment):

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

Attach additional sheets if necessary.

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IV – PATIENT'S AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: _____

Maiden or Previous Name(s): _____

Date of Birth: _____ SSN (last 4 digits) _____

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: (Please list each hospital, clinic, doctor below. Make additional copies of this page if more lines are needed.)

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

(A) Any and all information (to include, but not limited to all applicable medical records, x-rays, MRI's, 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 below to be released; **or instead**

☐ (B) ONLY the following information [Check only if applicable]:

- I understand the information is being disclosed and may be used only in connection with my claim for Disability Benefits from MFPRSI.

IV – B: RE-DISCLOSURE

- 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 to the following [Check 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.

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, in order for the above information to be released, I must sign here, and complete and sign Section IV – D of this form.

X _____ _____

Signature of Patient or Legal Guardian | Date of signing

_____

Street Address

_____

City | State | Zip Code

_____

Relationship, if NOT the patient

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:

[Place "YES" or "NO" on EACH line as applicable:]

_____ Substance Abuse [Drug or Alcohol] Information from:

(Name of agencies, facilities, or individuals)

_____ Mental Health Information from:

(Name of agencies, facilities, or individuals)

_____ AIDS-related Information, Diagnosis, and test results from:

(Name of agencies, facilities, or individuals)

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

X _____ _____

Signature of Patient or Legal Guardian | Date of signing

_____

Relationship, if NOT the patient