MFPRSI MUNICIPAL FIRE & POLICE RETIREMENT SYSTEM OF IOWA
7155 Lake Drive, Suite 201
West Des Moines, IA 50266
Phone: 515.254.9200
Toll Free: 888.254.9200
Fax: 515.254.9300
pensions@mfprsi.org
www.mfprsi.org

Memorandum

Re: Instructions for completing the application for a disability retirement

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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 MFPRSI.

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 MFPRSI 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 (MPO), and 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 MFPRSI'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)
- Sheriff or Deputy Sheriff as defined in section 97B.49C (IPERS)
- 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).
- Protection Occupation as defined under section 97B.49B.(IPERS)

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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 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 Chapter 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 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. Has there been a divorce decree or marital property order (MPO)? If "yes," attach a copy. 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 on the cover memo of this application? Yes ☐ No ☐

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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), here by 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), here by 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 Section II-A question 1 above must also complete questions 2-4 below of Section 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).

3. Reason for inability to perform duties.

Please identify the condition(s) and the causation(s) for each condition (e.g., "coronary artery disease" or "Injured lower back while lifting patient into ambulance").

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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 _____

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 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 MFPRSI.

☐ 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).

Chief's Signature _____ Date _____

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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) 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):

_____

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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 of this statement. The statement of assigned duties should pertain to the applicant's current position.

☐ Job description is attached.

☐ Job description **NOT** is attached.

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:

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Disability Retirement Application

Provide Additional Information, if necessary:

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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 or 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 _____

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 show the following:

Doctor's Name _____ Clinic _____

Street Address _____ City _____ State _____ Zip _____

Doctor's Email _____ Doctor's Phone _____

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".

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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 _____

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 _____ 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 ☐

Dates of Admissions: _____

Dates of Discharges: _____

Were you an outpatient? Yes ☐ No ☐
If "**yes**," provide the following information:

Dates of Visits: _____

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".

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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 | Patient or Clinic Number

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

Dates of Admissions: _____

Dates of Discharges: _____

Were you an outpatient? Yes ☐ No ☐
If "**yes**," provide the following information:

Dates of Visits: _____

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:

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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 lines are needed):

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

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 box only if applicable):

_____

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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

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

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____ _____ _____
Street Address City State Zip

_____
Relationship, if NOT the patient

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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 line as applicable:

Please note that answering "No" to the following requests may delay the collection of medical records and therefore delay the disability application process.

Yes ☐ No ☐ Substance abuse (drug or alcohol) information from:

_____
Name of agencies, facilities, or individuals

Yes ☐ No ☐ Mental health information from:

_____
Name of agencies, facilities, or individuals

Yes ☐ No ☐ 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**.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Relationship, if NOT the patient