Policemen's And Fire Fighter's Retirement Fund
Of The Lexington-Fayette Urban County Government

Application for Disability Retirement

Applicant: Last Name	First	Middle	Employee Number

Address	City	State	Zip

Social Security Number	Date of Birth	Home Phone Number

Division	Current or Last Assignment	Current of Last Work Phone Number

In accordance with the provisions of KRS 67A.360, I hereby apply for retirement based on (check one):

Total and Permanent Occupational Disability ☐

Total and Permanent Non-Occupational Disability ☐

If applying for a disability retirement, are you applying for the "additional service retirement annuity payment" authorized in KRS 67A.460 (4) (To qualify for this payment you must be eligible for a service retirement annuity under KRS 67A.410 (1) or (2) (check one).

Yes: ☐ No: ☐

I became a member of the Division of Police or Fire on: _____

As of the date of application I have completed _____ years and _____ months of service.

As of the date of application I have purchased _____ years and _____ months of service or a total of _____quarters of service credit.

As of the date of application I have a total service credit of _____ year's _____ months of service.

_____
Signature

Name of Applicant: _____

Please print or type all answers. If you need more space, please use additional forms. The information requested on this form will be used to document your claim of disability.

If applying for a disability retirement please list the condition(s) for which you are applying for disability benefits. Additionally, indicated the date of documentation for each condition you have indicated prevented you from performing your job. If no documentation exists please indicate "Not Reported".

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

Have you ever been treated for your disability? Yes _____ No _____

Were you ever admitted to a hospital for your disability? Yes _____ No _____

Provide the following information regarding all healthcare providers (for example: doctors, psychologists, therapists, hospitals, clinics, other medical providers or other agencies including Veterans Administration, Workers Compensation, Vocation Rehabilitation etc.) who have treated you concerning the conditions listed above regardless if this treatment was received prior to being a member of the Policemen's and Fire Fighter's Retirement Fund. If the information requested is unknown please provide as much information as possible. (Add on form available).

_____
Doctor / Facility Specialty

_____
Mailing address City State Zip

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Doctor / Facility Specialty

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Mailing address City State Zip

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Doctor / Facility Specialty

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Mailing address City State Zip

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Doctor / Facility Specialty

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Mailing address City State Zip

Doctor / Facility | Specialty

Mailing address | City | State | Zip

Doctor / Facility | Specialty

Mailing address | City | State | Zip

Have you applied for Worker's Compensation benefits? Yes ☐ No ☐ Date: _____

Have you received Worker's Compensation benefits? Yes ☐ No ☐ Date: _____

Have you applied for Social Security disability benefits? Yes ☐ No ☐ Date: _____

Have you received Social Security disability benefits? Yes ☐ No ☐ Date: _____

When did you first experience difficulty performing your job duties?

When did you first report you difficulties? (Provide copies of all SP302's to the pension office)

Did you continue to work after being injured? Yes ☐ No ☐

If "Yes" what enabled you to work?

Has your personal physician indicated you have reached Maximum medical Improvement?

Yes ☐ (If yes provide copy) No ☐

I, _____, hereby certify that all statements, medical information, job description, and application forms submitted relevant to my application for disability benefits are true, correct, accurate, and complete. The attached information consists of all the existing medical information regarding the condition(s) for which I am seeking disability retirement benefits. The medical information includes all existing medical records regardless of the membership date in the Policemen's and Fire Fighter's Retirement Fund. I am also aware that by signing this certification I am certifying that the medical records provided represent all the evaluations, examinations, and treatment I have had for the condition(s) for which I am applying for disability retirement benefits, including all reports of diagnostic medical testing performed on me. I understand that any willful misrepresentation, falsification of facts, or failure to report such treatments, may result in a denial of my application for disability retirement benefits as well as possibly subject me to civil action or criminal prosecution as provide by law.

_____ _____

Signature Date

_____ _____

Printed Name Social Security Number

TO BE COMPLETED BY NOTARY:

STATE OF KENTUCKY COUNTY OF: _____

On this _____ day of _____, the member whose name is signed above personally appeared before me and acknowledged the foregoing signature to be his/hers, and having been duly sworn by me, made oath that the statements made in the said instrument are true.

_____ _____

Notary Public Signature Date

_____ _____

Printed Name My Commission Expires

Action by Board: Approved: _____ Denied: _____ on this _____ day of _____ 20_____

Secretary: _____ Chair: _____