# CERTIFICATION BY PHYSICIAN
# OF THE CONTINUANCE OF TOTAL DISABILITY
# (4532 CONSOLIDATED RETIREMENT PLAN)

The 4532 Consolidated Retirement Plan of the City of Marietta requires that disability retirees certify their status at least every two years or when requested by the Pension Board. Please complete this form and fax it to the City of Marietta, Attention: Benefits Division, Fax Number: 770-794-5565 or mail as soon as possible to the City of Marietta, Human Resources Department, Attention: Benefits Division, 205 Lawrence Street NE, Marietta, GA 30060.

***TO BE COMPLETED BY THE RETIREE:***

Full Name: _____ Phone # _____

Date of Birth: _____ Last 4 digits of Social Security Number: xxx-xx-_____

_____
Street Address City State ZIP Code

Are you currently employed? ( ) Yes ( ) No If so, who is your employer? _____
Employer contact telephone _____

***I have read and understand the definition of disability and termination of disability benefit on page 2.***

_____ _____
Retiree's Signature Date

***TO BE COMPLETED BY THE PHYSICIAN (MUST BE COMPLETED IN FULL):***

1. In your medical opinion, does the retiree meet the definition of disability on page 2? ( ) Yes ( ) No

2. Current condition(s): _____
_____

3. Limitation(s): _____
_____

4. Expected duration of condition(s) and limitation(s): _____
_____

_____ _____
Physician's Name/Signature Date

_____ _____
Street Address Telephone Number

_____ _____
Street Address Line 2 Medical License Number & State

_____ _____
City State ZIP Code Type of Practice

# 4532 CONSOLIDATED RETIREMENT PLAN DISABILITY PROVISIONS

**DEFINITION OF DISABILITY:**

An employee will be considered disabled if unable, solely because of disease or accidental bodily injury, to work at his or her own occupation or at any reasonable occupation for which the employee is engaged, or may reasonably become engaged, fitted by education, training, or experience provided, however that such disability shall not have been self- inflicted, incurred in military service, incurred in the commission of a felonious enterprise, or the result of the use of narcotics and/or drugs and/or alcohol.

**TERMINATION OF DISABILITY BENEFIT:**

A period of total disability ceases on the earliest of the following dates:

A. The date the participant ceases to be totally disabled.
B. The date the participant commences work at a reasonable occupation means any gainful activity for which the employee is engaged, or may reasonably become engaged, fitted by education, training or experience.
C. The date the participant fails to furnish proof of the continuance of total disability or refuses to be examined when required.
D. The date the participant ceases to be under the care of a physician.
E. The date of the participant's death.

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Thank you for your assistance. If you have any questions, please contact the Benefits Division at 770-794-5564 or 770-794-5569.