Application for Disability Retirement

Human Resources
205 Lawrence Street NE
Marietta, GA 30060
770-794-5562

Please mail application to address at left or fax form to: 770-794-5565

The information in this form will be used to determine your eligibility for disability benefits and to gather a complete list of your medical providers.

As the applicant for disability benefits, you are responsible for gathering and submitting to the Pension Board all medical and other information you believe relates to your ability or inability to work. After its receipt of your information, the Pension Board may require you to be evaluated by another provider or send your records to another provider for input on your ability or inability to work.

EMPLOYEE STATEMENT

To be completed by the employee.
Please call 770-794-5564 if you need help completing this application.
ALL FORMS MUST BE FULLY COMPLETED FOR CONSIDERATION.

1. NAME	2. SEX: ☐M ☐F	3. EMPLOYEE NUMBER
4. ADDRESS		5. DATE OF BIRTH
		6. E-MAIL
7. TELEPHONE NUMBERS: HOME ( ) WORK ( ) CELL ( )		8. LENGTH OF SERVICE _____ Years _____ Months
9. JOB TITLE		
10. PAYROLL STATUS: On Payroll & Receiving Salary?		☐ Yes ☐ No If No, Explain.
11. I SEEK DISABILITY BENEFITS BECAUSE OF THE FOLLOWING MEDICAL CONDITION(S): (Use additional sheets if required)		

TREATING PHYSICIANS FOR MEDICAL CONDITION(S) LISTED IN ITEM 11 (Use additional sheets if required)

Primary Care Physician	Doctor	Doctor
Medical Specialty	Medical Specialty	Medical Specialty
Street	Street	Street
City, State and ZIP Code	City, State and ZIP Code	City, State and ZIP Code
Doctor	**Doctor**	**Doctor**
Medical Specialty	Medical Specialty	Medical Specialty
Street	Street	Street
City, State and ZIP Code	City, State and ZIP Code	City, State and ZIP Code

HOSPITALIZATION(S) FOR MEDICAL CONDITIONS LISTED IN ITEM 11

Hospital	**Dates of Admission**	Hospital	**Dates of Admission**
Street		Street	
City, State and ZIP Code		City, State and ZIP Code	

ACCIDENT(S) OR OCCURRENCE(S). PLEASE DESCRIBE ANY OTHER OCCURRENCES THAT MAY BE RELATED TO YOUR CLAIMED DISABILITY. (Use additional sheets if required)

_____

_____

_____

_____

_____

APPLICANT SIGNATURE

I certify that the information contained on this form is true.

_____ _____

Applicant Signature ***(Must sign name in full)*** Date

_____

Applicant Name - Please Print

DISABILITY PROVISIONS

UNDER THE PLAN, YOU MUST MEET THIS DEFINITION OF DISABILITY TO BE DECLARED INITIALLY ELIGIBLE FOR BENEFITS:

A participant 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 participant may be engaged, or may reasonably become engaged, fitted by education, training or experience provided, however, that such disability shall not have been (a) self-inflicted; (b) incurred in military service; (c) incurred in the commission of a felonious enterprise; or (d) the result of the use of narcotics and/or drugs and/or alcohol.

IF DISABILITY BENEFITS ARE AWARDED, THEY MAY BE TERMINATED AS FOLLOWS:

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.

PERSONAL PRIVACY PROTECTION LAW - The Retirement Plan is required by law to maintain records to determine eligibility for and calculate benefits. Failure to provide information may interfere with timely payment of benefits. The official responsible for record maintenance is the Benefits Manager.

Application for Disability Retirement for Employees of the City of Marietta

PHYSICIAN STATEMENT

To be completed by the Primary Treating Physician
Please Note: Completion of this entire form is required.

DIAGNOSIS

Patient's condition is the result of: Sickness ☐ Injury ☐
Is condition due to illness or an injury that is work related? Yes ☐ No ☐

Primary diagnosis: _____

Secondary diagnosis: _____

Subjective symptoms at most recent appointment:
_____

Pertinent Test Results (list all results, or enclose test):

Test: _____ Date: _____ Results: _____

Test: _____ Date: _____ Results: _____

Physical Examination Findings: _____

_____

Current Medications, Dosage and Frequency: _____

TREATMENTS

Date your patient reported stopping work: _____

Date you first treated this patient: _____ Date you first treated this patient for this condition: _____

Date of reported onset of this condition: _____ Date of most recent treatment: _____

How often has patient been seen/treated for this condition? _____ Date of next office visit: _____

Has patient been referred to any other physician? Yes ☐ No ☐ If "Yes" Date(s): _____

Name of Physician(s): _____

Telephone Number of Physicians(s): (___)_____ Specialty: _____

Has surgery been performed? Yes ☐ No ☐

If "Yes" Name of Hospital: _____ Telephone Number of Hospital: (___)_____

Date(s) admitted: _____ Date(s) Discharged: _____

REFERRING PHYSICIAN

Was patient referred to you by another physician? Yes ☐ No ☐

Please provide the following information for referring doctor:

Name: _____

Address: _____

Telephone Number: (___)_____ Fax Number: (___)_____

DEFINITION OF DISABILITY

The City of Marietta's Code, Section 4-12-6-010 Article II, Section 6, defines disability as being 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 participant may be engaged, or may reasonably become engaged, fitted by education, training or experience; provided, however, that such disability shall not have been (a) self-inflicted; (b) incurred in military service; (c) incurred in the commission of a felonious enterprise; or (d) the result of the use of narcotics and/or drugs and/or alcohol.

QUESTIONS

In your medical opinion, does the applicant meet the definition of disability stated above? __ Yes ___ No

What is the basis for your opinion (please address any current limitations and the expected length of time such limitations are expected to continue):

_____

_____

_____

_____

PHYSICIAN CERTIFICATION

Primary Physician's Name (Please print or type):		Physician's Specialty:
Telephone Number: ( )	Fax Number: ( )	EIN Number:
Group Name:		License Number:
Mailing Address:		City, State, ZIP Code:

I certify that the information contained in this Physician Statement, and any attachments to it, is accurate.

Signature: _____ Date: _____

Please return completed form to:
City of Marietta **Fax: 770-794-5565**
ATTN: Human Resources Department/Benefits Manager
205 Lawrence Street NE
Marietta, GA 30060

Please contact the Benefits Manager if you have any questions regarding completing the form: 770-794-5564.