

Disability Process and Application Instructions:

1. The following documentation must be completed and returned to the Pension Office:
 - a. Application for Disability Retirement - 4 pages
 - b. Authorization for the Release of Information - 1 page
 - c. Supplement Questionnaire - 1 page
 - d. Job Responsibilities (fit for duty) – 3 pages

The job responsibilities (fitness for duty) form must be completed by the treating physician and state that the applicant has reached MMI (Maximum Medical Improvement).

- e. SP302 and/or Health & Safety Report(s)
- f. Medical Records

The employee must provide the pension office with two (2) one-sided copies of all medical records, physical therapy notes and doctor notes pertaining to the condition(s) listed on the application. No double-sided copies or electronic records will be accepted. If MRI and/or x-ray images exist, please take the discs to the appointments scheduled by the pension office.

2. Upon completion and submission of the requested documentation and with the consent of the Board members, the applicant will be required to undergo a minimum of two medical examinations by physicians chosen by the Police and Fire Pension Board. The scheduling of these appointments will be coordinated through the pension office.
3. Once the two medical examinations are scheduled, a letter containing appointment information will be sent to the applicant's home address. At no point during this process should an applicant contact the doctor's office and request information pertaining to the evaluation and/or request a new appointment date or time. If you have a scheduling conflict, please contact the pension office.
4. After the physician completes the applicant's examination, a report will be submitted to the pension office. Once both reports are received the applicant will be contacted by the pension administrator and the reports will be disseminated to the Police and Fire Pension Board for a decision.

At the discretion of the Board, additional examinations may be required during the application process or any time while receiving disability benefits. Failure to comply may result in the denial or cessation of disability benefits.

5. If you have questions about the disability process, please contact the Pension Office.

POLICE AND FIRE RETIREMENT FUND

Application for Disability Retirement

Last Name First Name Middle Name Employee Number

Address City State Zip

Home Phone Number Mobile Phone Number

Division Current or Last Assignment Personal Email Address

In accordance with the provisions of KRS 67A.360, I am applying for retirement based on:

Total and Permanent Occupational Disability: _____

Total and Permanent Non-Occupational Disability: _____

In accordance with KRS 67A.460(4), if a member is eligible for a service retirement annuity under KRS 67A.410 and that annuity would exceed the amount of his or her total and permanent occupational disability annuity, the member may elect to receive an additional service retirement annuity payment. If you would like to request the additional service retirement annuity, please check "yes". If you are ineligible for a service retirement, please check "no".

Yes: _____ No: _____

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

**For any member of the police department hired prior to March 14, 2013, this would be your sworn date.*

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.

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

For Pension Office Use Only: The member has purchased _____ quarters with their sick payout.

Signature

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

Name of Applicant: _____

Please list the condition(s) and date(s) for which you are applying for disability benefits. If the injury was documented using a SP302 and/or Health & Safety report, please use the date the injury occurred. If the injury was not documented, please state "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: _____

Please provide the requested information for every medical provider used to examine and/or treat the condition(s) you are seeking disability retirement benefits, regardless if the treatment was received prior to your membership date in the Police and Fire Retirement Fund.

***You must also list any provider used during a workers' compensation claim and/or lawsuit.**

Doctor/Facility Specialty

Mailing Address City State Zip

Doctor/Facility Specialty

Mailing Address City State Zip

Doctor/Facility Specialty

Mailing Address City State Zip

Doctor/Facility Specialty

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 workers' compensation benefits? Yes: _____ No: _____ Date: _____

Have you received workers' compensation benefits? Yes: _____ No: _____ Date: _____

When did you first experience difficulty performing your job duties?

When did you first report your difficulties?

Did you continue to work after being injured? Yes: _____ No: _____

If you answered "yes", what enabled you to work?

Has your treating physician indicated you have reached maximum medical improvement?

Yes: _____ No: _____

I, _____, hereby certify that all statements, medical information, documents, reports, descriptions and forms submitted and/or listed on 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 Police and Fire Retirement Fund. By signing this application I am certifying that the medical records provided represent all evaluations, examinations, diagnostic testing and treatment I have undergone for the condition(s) for which I am applying for disability retirement benefits. I understand that any willful misrepresentation, falsification of facts, or failure to report such treatments may result in denial of disability retirement benefits and may also subject me to civil action or criminal prosecution as provided by law.

Signature: _____ Date: _____

Printed Name: _____

TO BE COMPLETED BY NOTARY PUBLIC:

STATE OF KENTUCKY

COUNTY OF: _____

The foregoing instrument was acknowledged before me this _____ day of _____ (month), _____ (year), by _____ (name of person acknowledged).

Notary Public Signature: _____

Notary Public Printed Name: _____ Date: _____

My Commission Expires: _____

Commission Number: _____

Action by Board:

Approved: _____ Denied: _____ on this _____ day of _____ 20 _____

Secretary: _____ Chair: _____