



Ohio Police & Fire Pension Fund
 140 East Town Street
 Columbus, OH 43215
 Phone: 888-864-8363
 Fax: (614) 628-1777
www.op-f.org

DISABILITY BENEFIT APPLICATION

Please complete this form and file it with the Ohio Police & Fire Pension Fund (OP&F) if you are an eligible OP&F member who wishes to apply for disability benefits. You may qualify for disability benefits if you are no longer able to perform your official duties due to a mental or physical disability, or a combination of disabling conditions and you timely file the applications with OP&F.

To apply for disability benefits, you must be making contributions to OP&F or, if you are no longer actively contributing to OP&F, you must have kept your contributions on deposit and file the disability application within one year from the date that you are placed on administrative leave or terminate your employment. Failure to meet this one-year deadline results in an automatic denial of this application. It is not necessary to terminate employment before applying for disability benefits. If the one-year deadline is approaching, you may file this application with OP&F to ensure your eligibility and submit required reports at a later time.

For more information about disability benefits, or your right to revoke this application, please refer to the *Member's Guide to Disability Retirement*, or contact OP&F Customer Service for assistance.

Except as noted above, to avoid a delay in processing your paperwork, please complete all sections of this application. If a section of this application does not apply to your situation, please mark with "N/A" for not applicable.

Section A: Member information

Name: First, MI, Last, suffix (Jr. III, etc.)		<input type="checkbox"/> Police officer <input type="checkbox"/> Male <input type="checkbox"/> Firefighter <input type="checkbox"/> Female	Social Security number											
Street Address / Post office box		<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td> </tr> </table>												
City, State, ZIP code		Date of Birth												
Home phone <input type="checkbox"/> New		Alternate phone <input type="checkbox"/> New		Email address <input type="checkbox"/> New										
Marital status		Marriage date / Divorce date												
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married but previously divorced <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td><td style="width: 20px;"> </td> </tr> </table>												

Section B: Dependent information

Relationship	Dependent's name	Gender (M or F)	Social Security Number	Birth date
Spouse	_____	_____	_____	_____
Children, aged less than 18	_____	_____	_____	_____
Children, aged 18-22, if unmarried and a student	_____	_____	_____	_____
Children any age, if dependent and disabled	_____	_____	_____	_____

Section C: Employment history

Employer	Department/Rank
Service rendered (number of years / number of months)	Full-time appointment date / Termination date

Please indicate your current payroll status (check all that apply):

- Regular duty
- Light duty
- Vacation
- Sick leave
- Injury leave
- Leave-of-absence
- Terminated
- Drawing workers' compensation benefits

You may purchase credit for active duty military service, certain leaves-of-absence, or for full-time service under any Ohio public retirement system, subject to certain restrictions. Please check any of the following that apply to you, so OP&F can notify you if you are eligible to purchase credit to increase your pension. OP&F reserves the right to audit the information you provide in this section.

- Military (active duty only) Date(s): _____
- P.O.W. Date(s): _____
- State Highway Patrol Retirement System Date(s): _____
- Ohio Public Employees Retirement System Date(s): _____
- State Teachers Retirement System Date(s): _____
- School Employees Retirement System Date(s): _____
- Cincinnati Retirement System Date(s): _____
- Police or fire service (not reported above in Service Rendered) Date(s): _____
- Leave-of-absence from police or fire service due to medical disability Date(s): _____
- Layoff Date(s): _____
- Federal/out-of-state public service Date(s): _____
- Other: _____ Date(s): _____

Section D: Multiple Ohio retirement system membership

Yes No Are you **currently receiving**, or eligible to receive in the future, an age/service or disability retirement benefit from any of the following Ohio retirement systems? (Please check all that apply.)

- Ohio Highway Patrol Retirement System
- Ohio Public Employees Retirement System
- State Teachers Retirement System of Ohio
- Ohio School Employees Retirement System
- Cincinnati Retirement System

If you answered yes to the previous question, please state your effective date of retirement or the future date you will be eligible to receive a benefit. _____

Yes No Are you **currently contributing** to any of the following Ohio retirement systems? (Please check all that apply.)

- Ohio Highway Patrol Retirement System
- Ohio Public Employees Retirement System
- State Teachers Retirement System of Ohio
- Ohio School Employees Retirement System
- Cincinnati Retirement System

If you answered yes to the previous question, please provide your employer's name, address, and date of hire. _____

Section E: Medical history

Please list the conditions that you believe are disabling, in order of severity (attach additional pages if necessary). It is important that you include all conditions you feel are disabling. You may be required to submit a copy of your pre-employment physical if it is not already on file with OP&F, or a letter stating that it is not available. If you have heart disease, cardiovascular disease, or chronic respiratory disease and there is no pre-employment physical, you must provide documentation that these conditions are disabling as a result of the performance of your official duties as a police officer or firefighter with an OP&F-covered employer.

Disabling condition	Date of onset
Description of accident or illness	Workers' compensation number <input type="checkbox"/> No claim was filed
Disabling condition	Date of onset
Description of accident or illness	Workers' compensation number <input type="checkbox"/> No claim was filed
Disabling condition	Date of onset
Description of accident or illness	Workers' compensation number <input type="checkbox"/> No claim was filed

Please list the attending physician(s) who are treating you at this time only, and who will be submitting reports.

Physician's name	Practice or specialty
Address	Phone number
Physician's name	Practice or specialty
Address	Phone number

Please list the dates of recent hospitalizations for disabling conditions for which you will be submitting reports. If you have not been hospitalized for these disabling conditions, mark with "N/A" for not applicable. Attach hospital records, specifically the discharge summaries of your pertinent inpatient hospital admissions, the results of any special diagnostic tests, and consultation reports. If you have undergone an involved diagnostic procedure on an outpatient basis, e.g. stress test, and will be submitting the report, please record the date and site of the test.

Hospital name	Date admitted / date discharged
Address	Phone number
Hospital name	Date admitted / date discharged
Address	Phone number

Section F: Member signature and acknowledgement

I, the member described in Section A of this Disability Benefit Application, having been duly sworn, represent that I am the person herein described; it is my will and intent to apply for disability benefits under Chapter 742 of the Ohio Revised Code; I understand that this application will not be processed until received by OP&F, and determination of my eligibility to file this application has been determined by OP&F; and that the statements made herein are true and correct.

I certify, under penalties of perjury, that I have reviewed this OP&F application for disability benefits and all statements and documents supporting my application are truthful and accurate. I understand that if the statements and/or documents supporting the application are proven to be false it may result in the termination of any benefits that may be payable to me, as well as possible civil and criminal penalties.

Member's signature:

Date of signature:

Section G: Notary public requirement

The notary public in good standing must sign in the space provided in this section and affix their seal.

State of _____, County of _____, ss:

The foregoing *Disability Benefits Application* was acknowledged before me by the member named in the foregoing Section A, this _____ day of _____, 20_____.

Affix Seal here

Notary's signature:

Print name:

My commission expires: