



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

## NOTICE OF DISABILITY APPEAL

Please complete this form and file it with the Ohio Police & Fire Pension Fund (OP&F) if your application for benefits is denied or if you disagree with the grant awarded at the Board of Trustees initial determination hearing and you want to appeal the action. You must file this Notice of Appeal with OP&F within 90 days of your receipt of the Board of Trustees initial determination of your application for disability benefits. If you do not file a Notice of Appeal within this time period, the Board of Trustees will not act on your appeal.

Within 60 days of filing this Notice of Appeal, you must file with OP&F all documents that you desire to submit in support of your appeal. In order to avoid delay in the processing of your appeal, you are encouraged to submit all documents in a single package. The Board of Trustees has already considered all reports and medical records you have previously sent to OP&F in support of your application for disability benefits, so these documents do not need to be re-submitted. New or other physicians' reports, statements, or medical records which amplify or provide a more current evaluation of your medical condition will be helpful to your appeal. If you fail to submit supporting documents within the 60-day time period, the Board of Trustees may dismiss your appeal. If you require more than 60 days to obtain supporting documentation, you may request an extension by filing a Request for Extension form with OP&F before the expiration of the 60-day deadline. In no event can the extensions, in the aggregate, exceed one year.

You will be notified of the date and time of your appeal hearing by mail. Your attendance is not mandatory; however, you are encouraged to attend in order to answer any questions that the physician, vocational evaluator, or Board of Trustees may have regarding your appeal. You will be notified of the Board of Trustees' decision regarding your appeal in writing within 30 days of your appeal hearing.

### Section A: Member information

Name: First, MI, Last, suffix (Jr. III, etc.)		Social Security Number
Street Address / Post office box		Date of Birth
City, State, ZIP code		Date of initial disability hearing
Home phone:	Alternative phone:	

### Section B: Basis for appeal

Please provide a detailed basis for appealing the decision by the OP&F Board of Trustees. Be certain to state the specific impairments that are at issue and that will be supported with new or other physicians' reports, statements or medical records.

Condition being appealed:	Reason:	Is new medical information provided?
1		<input type="checkbox"/> YES <input type="checkbox"/> NO
2		<input type="checkbox"/> YES <input type="checkbox"/> NO
3		<input type="checkbox"/> YES <input type="checkbox"/> NO
4		<input type="checkbox"/> YES <input type="checkbox"/> NO

**(OP&F OFFICE USE ONLY)** IDH date: \_\_\_\_\_

### Section C: Educational experience

<b>HIGH SCHOOL</b>	School Name	Years attended	Degree or major	<input type="checkbox"/> Graduated
<b>COLLEGE</b>	School Name	Years attended	Degree or major	<input type="checkbox"/> Graduated
<b>VOCATIONAL SCHOOL</b>	School Name	Years attended	Degree or major	<input type="checkbox"/> Graduated

### Section D: Vocational experience

Are you currently employed?

Yes       No

If yes, please indicate your employment status:

Hours worked per week: \_\_\_\_\_

Self employed

Employed by: \_\_\_\_\_ position: \_\_\_\_\_

Are you currently receiving workers' compensation benefits?

Yes       No

If yes, please indicate what benefits you are receiving.

Medical expenses       Temporary partial

Permanent partial       Temporary total

Permanent total

Are you receiving Social Security benefits?

Yes       No

Please describe all work experience other than as a police officer or firefighter below. Attach additional pages if necessary.

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### Section E: Member signature and acknowledgement

I, the member described in Section A of this *Notice of Disability Appeal* form, who, having been duly sworn, represent that I am the person herein described; it is my will and intent to appeal the Board of Trustees' initial determination hearing regarding my application for disability benefits; and that all statements included 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 F: Notary public requirement for member signature

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 *Notice of Disability Appeal* 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: