Ohio Police & Fire Pension Fund
140 East Town Street
Columbus, OH 43215
Phone: 1-888–864–8363
Fax: (614) 628–1777
www.op–f.org

DISABILITY BENEFIT APPLICATION

Please read OP&F's *Member's Guide to Disability Benefits* prior to completing this application. If you have questions about eligibility, deadlines, or any part of the disability process, you are encouraged to speak with an OP&F disability case manager by phoning 888-864-8363.

- Once processed, OP&F must notify your employer that a person with your position or rank has filed a Disability Benefit Application. However, you will not be identified by name.
- Any misrepresentation of the facts relating to your Application might result in civil and criminal penalties, in addition to the termination of your disability benefits.

If this Application is filed by a person other than the member listed in Section A below, please attach a power of attorney or letter of guardianship (this person cannot self-designate as a beneficiary without a power of attorney). Unless otherwise incapacitated, this application should be completed by the member named below.

Complete Sections A through O and answer all questions. If a section does not apply to your situation, indicate "N/A" for "Not Applicable." Sections K and N must be completed in the presence of a Notary Public after swearing or affirming under oath. Submit all pages of completed application to address above. Please type or print using blue or black ink.

Section A: Member information

Name: First, MI, Last, suffix (Jr., III, etc.) ☐ Male ☐ Female

Last 4 digits of Social Security Number ☐☐☐☐ *(OP&F use only)*

Street Address / Post office box

City, State, ZIP code

Date of Birth ☐☐/☐☐/☐☐☐☐

Primary phone ☐ New | Alternate phone ☐ New | Email address ☐ New

Employer (current or most recent) | Division ☐ Police ☐ Fire | Job title or rank

Current payroll status (check all that apply)

- ☐ Unrestricted/full duty
- ☐ Restricted/light duty since: _____
- ☐ Using vacation/sick time to remain on payroll
- ☐ Paid injury leave, since: _____
- ☐ Paid administrative leave, since: _____
- ☐ Receiving workers' compensation benefits
- ☐ Voluntary separation effective: _____
- ☐ Involuntary separation effective: _____
- ☐ Other: _____

Section B: Other Ohio retirement systems

List your status with the Ohio retirement systems below. Check all that apply.

☐ **Member has no association with an Ohio retirement system, other than OP&F**

	Currently receiving service or disability benefits	Currently contributing	Contributed prior to OP&F membership	Prior contributions were for full-time employment	Dates of full-time employment prior to OP&F membership, or, if currently receiving retirement benefits, list retirement date
Ohio Highway Patrol Retirement System	☐	☐	☐	☐	
Ohio Public Employees Retirement System	☐	☐	☐	☐	
State Teachers Retirement System of Ohio	☐	☐	☐	☐	
Ohio School Employees Retirement System	☐	☐	☐	☐	
Cincinnati Retirement System	☐	☐	☐	☐	

Section C: Secondary employment

List any occupation or business you were engaged in while also working as a police officer or firefighter:

Occupation	Employer	Dates of employment	
		From:	*To:*
		From:	*To:*
		From:	*To:*

Section D: Dependents

MARITAL HISTORY

List all marriages and domestic relations matters, starting with the current/most recent spouse and working backwards chronologically. Attach a separate sheet if necessary. If married, please submit marriage and birth certificates. Please submit complete, file-stamped copies of any and all decrees of divorce, dissolution and legal separation, including copies of separation agreements.

☐ **Member has never been married**

Name First, MI, Last, suffix (Jr., III, etc.)	**Social Security number**	**Date of birth** (mm/dd/yyyy)	**Gender**	**Marriage date** (mm/dd/yyyy)	**Divorce date** (mm/dd/yyyy)	**Current spouse**
			☐ Male ☐ Female			☐
			☐ Male ☐ Female			

DEPENDENT CHILDREN

List all dependent children (up to age 22) and incapacitated children (any age). Attach a separate sheet if necessary. Please submit birth certificates for all dependent children.

☐ **Member has no dependent children**

Name First, MI, Last, suffix (Jr., III, etc.)	**Social Security number**	**Date of birth** (mm/dd/yyyy)	**Gender**	**Relationship**	**Marital status**	**Disabled/ incapacitated**
			☐ Male ☐ Female	☐ Natural child ☐ Adopted ☐ Step-child	☐ Single ☐ Married	☐
			☐ Male ☐ Female	☐ Natural child ☐ Adopted ☐ Step-child	☐ Single ☐ Married	☐
			☐ Male ☐ Female	☐ Natural child ☐ Adopted ☐ Step-child	☐ Single ☐ Married	☐
			☐ Male ☐ Female	☐ Natural child ☐ Adopted ☐ Step-child	☐ Single ☐ Married	☐

Section E: Self-assessment

Using only the space provided below, explain why you are permanently disabled from performing the duties of your title/rank: *(please type or print legibly)*

Section F: Disabling medical condition(s)

The Board of Trustees can grant a disability benefit to a member who has a condition of disability for which there is no present indication of recovery. The following guidelines will help you list your permanently disabling conditions in this Section.

1. List only medical conditions you feel permanently incapacitate you from fulfilling the requirements of your job title/rank.
2. Where possible, group multiple disabling injuries from a common incident or condition together. For example:

1	Disabling condition: **Cardiac**	Body part(s) affected or specific diagnoses: **Heart disease, ischemia, angina, hypertension**	Date of onset: **05/09/2008**

You can also group similar or recurring diagnoses together. For example:

1	Disabling condition: **Psychiatric**	Body part(s) affected or specific diagnoses: **Depression, anxiety**	Date of onset: **June 2011**

SUBMITTING SUPPORTING MEDICAL DOCUMENTATION:
In order to evaluate the extent of your disabling medical conditions, OP&F's independent medical examiners and Disability Evaluation Panel (DEP) physicians rely on you to support your application with *objective*, *recent* and *relevant* medical documentation:

OBJECTIVE Most disabling physical conditions can be evaluated, in part, by reviewing the results of objective medical tests. Examples include, but are not limited to, MRIs, X-rays, EMGs, laboratory results, operative reports and hospital discharge summaries. Send only narrative reports.

RECENT Submit only the results of most recent diagnostic tests for each disabling condition, illness or injury. As a general guideline, a diagnostic test performed more than two years ago is not "recent."

RELEVANT Submit only information that is relevant to each disabling condition you list in this Section.

PROVING ON-DUTY ILLNESS OR INJURY
An "on-duty illness or injury" means an illness or injury that occurred during, or resulted from, the performance of official duties under the direct supervision of a member's appointing authority. Notices of allowed BWC claims, injury reports signed by a supervisor and valid pre-employment physicals are examples of documents commonly used to evaluate duty-relatedness.

WHAT SHOULD I SEND?
While gathering documentation in support of your Application, you may feel overwhelmed after amassing hundreds of pages of records. By sending in only OBJECTIVE, RECENT and RELEVANT information, your case can best be prepared and evaluated. By observing the suggestions below, your case can be processed and assessed more efficiently.

Items that typically *do not* support your case, and should not be sent:

- Diagnostic report of each type of test (MRI, X-ray, labs, etc.) older than the past two years (send only the most recent reports)
- Chart notes (doctor's office, physical therapy, chiropractic, etc.)
- The following BWC documents: application, C-92 motions, court date/provider changes, ID card, witness statements/memorandums
- BWC claims unrelated to your listed "Disabling medical condition(s)" in this Section
- Emergency Room ("ER") or EMS run reports
- Return to work/time-off documents
- Fire station notes
- Letters of support from anyone you have known less than a year
- Family photos, awards, citations, achievement certificates, diplomas

Please use paper clips or clasps. Do not staple. Please remove duplicates. Place documents in date order (most recent on top).

Beginning with the most disabling, on the following pages list those disabling medical conditions which prevent you from performing your job. Submit a *Report of Medical Evaluation by Member's Attending Physician* from at least one current attending physician. If you have more than four conditions, you can make a copy of Page 5 and continue numbering.

Section F: Disabling medical condition(s) (continued)

1

Disabling condition:	Body part(s) affected or specific diagnoses:	Date of onset:
Current attending physician:	Specialty:	Initial office visit date:
Is the current attending physician submitting a report? ☐ Yes ☐ No		Most recent visit date:

List the medical documentation being submitted in support of this condition. Ex. MRI, X-ray, EMG, discharge summary, etc. If the same test/procedure has been performed multiple times, submit only the most recent date.

Document	*Date*	*Document*	*Date*

Is the disabling condition duty-related? ☐ No ☐ Yes

If yes: was an injury reported? ☐ No ☐ Yes

was a BWC claim filed? ☐ No ☐ Yes #_____ ☐ Settled-Medical ☐ Settled-Indemnity

2

Disabling condition:	Body part(s) affected or specific diagnoses:	Date of onset:
Current attending physician:	Specialty:	Initial office visit date:
Is the current attending physician submitting a report? ☐ Yes ☐ No		Most recent visit date:

List the medical documentation being submitted in support of this condition. Ex. MRI, X-ray, EMG, discharge summary, etc. If the same test/procedure has been performed multiple times, submit only the most recent date.

Document	*Date*	*Document*	*Date*

Is the disabling condition duty-related? ☐ No ☐ Yes

If yes: was an injury reported? ☐ No ☐ Yes

was a BWC claim filed? ☐ No ☐ Yes #_____ ☐ Settled-Medical ☐ Settled-Indemnity

Section F: Disabling medical condition(s) (continued)

3

Disabling condition:	Body part(s) affected or specific diagnoses:	Date of onset:
Current attending physician:	Specialty:	Initial office visit date:
Is the current attending physician submitting a report? ☐ Yes ☐ No		Most recent visit date:

List the medical documentation being submitted in support of this condition. Ex. MRI, X-ray, EMG, discharge summary, etc. If the same test/procedure has been performed multiple times, submit only the most recent date.

Document	*Date*	*Document*	*Date*

Is the disabling condition duty-related? ☐ No ☐ Yes

If yes: was an injury reported? ☐ No ☐ Yes

was a BWC claim filed? ☐ No ☐ Yes #_____ ☐ Settled-Medical ☐ Settled-Indemnity

4

Disabling condition:	Body part(s) affected or specific diagnoses:	Date of onset:
Current attending physician:	Specialty:	Initial office visit date:
Is the current attending physician submitting a report? ☐ Yes ☐ No		Most recent visit date:

List the medical documentation being submitted in support of this condition. Ex. MRI, X-ray, EMG, discharge summary, etc. If the same test/procedure has been performed multiple times, submit only the most recent date.

Document	*Date*	*Document*	*Date*

Is the disabling condition duty-related? ☐ No ☐ Yes

If yes: was an injury reported? ☐ No ☐ Yes

was a BWC claim filed? ☐ No ☐ Yes #_____ ☐ Settled-Medical ☐ Settled-Indemnity

Section G: Workers' compensation claims

Other than those listed in Section E, do you have any "allowed" Ohio Bureau of Workers' Compensation claims?
☐ Yes ☐ No. If yes, enter the injury status information for each claim below. Attach additional sheet if necessary.

Claim #	Claim status	Injury date	Do the injuries allowed in this claim permanently disable you from your job title/rank today?

Section H: Any other claims

Do you currently have a claim related to the injuries/conditions included in this application in any other forum or proceeding (i.e, court case, insurance)? ☐ Yes ☐ No. If yes, check what type of claim:

☐ Civil proceeding ☐ Veterans Administration ☐ Social Security ☐ Other:_____

Section I: Medications

Are you taking any prescription medications? ☐ Yes ☐ No. If yes, list medications below. Attach additional sheet if necessary.

Medication Name	Dosage (ex. 50 mg)	Frequency (ex. once daily)	Prescribing physician

Section J: Hospitalization, treatment and testing

Were you admitted to a hospital for any of the disabling conditions listed in Section F? ☐ Yes ☐ No
If yes, list the most recent admission for each condition in which you will be sending a discharge summary/operative report.

Hospital	City, State	Admittance date	Discharge date	Condition/reason

Have you previously been hospitalized or diagnosed with cancer, cardiac, pulmonary, or respiratory disease? ☐ Yes ☐ No
If yes, list the condition and date of diagnosis:

Condition	When were you first diagnosed?

Section K: Member authorization and affidavit

This section must be completed in the presence of a Notary Public after swearing or affirming an oath.

TO THE NOTARY PUBLIC: Prior to completing the section below, please adequately identify the affiant, administer an oath or affirmation to the affiant (ex. "Do you affirm that the facts set forth in the affidavit are true?"), have the affiant sign the affidavit in your presence and complete and execute the certification below.

MEMBER AUTHORIZATION AND AFFIDAVIT

- I authorize any licensed physician, medical provider, medical facility or provider of health care or similar entity to release any and all of the following information to OP&F or its third party administrators: Medical information with respect to any physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, and mental health. I understand that if there are any expenses for releasing this information, it is my responsibility to pay those expenses.
- I hereby provide written authorization as required by the Fair Credit Reporting Act (FCRA), 15 U.S.C. §1681-1681y, to furnish consumer reports, including Ohio Bureau of Workers' Compensation claim information.
- I understand the information obtained will be included as part of the proof of claim and will be used to determine eligibility for benefits, return to employment opportunities, and assessment of ongoing treatment. Any information obtained will not be released to any person or organization except OP&F and its third party administrators.
- I agree that a photographic copy of this Authorization shall be as valid as the original. I understand that I may request a copy of this Authorization. This Authorization shall become effective on the date appearing next to my signature below.
- Being duly sworn, I, the member described in Section A, state that the information I provided in this Application is complete and true to the best of my knowledge and belief. I understand that, by applying for disability benefits, I am consenting to undergo medical examinations by an OP&F-appointed, independent medical examiner(s) and/or vocational evaluator(s) and authorize my physician(s) to provide OP&F with my medical information.
- I acknowledge that, if my application is approved, I must accept the award and terminate employment not later than ninety days after receiving written notice of the disability award. I acknowledge that if I do not meet this deadline, my application will be void, my disability benefit will not be paid and will be forfeited, and, if I am eligible, I may file a new disability application.
- I acknowledge that I have received and reviewed OP&F's *Member's Guide to Disability Benefits* concerning disability benefits. If I am approved by the OP&F Board of Trustees for disability benefits, I acknowledge that this approval may be contingent upon my receiving continued treatment for my disabling condition(s). Additionally, I acknowledge that my disability benefits will be terminated should I return to work as a police officer or firefighter, as defined in Rule 742-3-20 of the Ohio Administrative Code.

Member's signature: ▶	Date of signature:

Section L: 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 Benefit Application* was sworn or affirmed before me and signed in my presence by the member named in the foregoing Section A, this _____ day of _____ , 20_____.

Affix Seal here	Notary's signature: ▶
	Print name:
	My commission expires:

Section M: **CANCER PRESUMPTION Questionnaire**

Ohio law provides that a member of a **fire department** who is disabled as a result of cancer is presumed to have incurred the cancer while performing his or her official duties under certain circumstances. The presumption can be rebutted in certain situations. To assist OP&F in identifying if you are eligible for this presumption, please complete the following information:

1	☐ Yes ☐ No	Are you currently an employee of the fire department listed in Section A of this Disability Benefit Application?
2	☐ Yes ☐ No	Have you been assigned to at least six years of hazardous duty as a firefighter (Hazardous duty is defined as duty performed under circumstances in which an accident could result in serious injury or death)?
3	☐ Yes ☐ No	Have you been exposed to an agent classified by the International Agency for Research on Cancer (IARC) or its successor agency as a Group 1 or 2A carcinogen?
4	☐ Yes ☐ No	Has it been less than 15 years since you were last assigned to hazardous duty as a member of a fire department?
5	☐ Yes ☐ No	Are you under the age of 70?
6	☐ Yes ☐ No	Are you currently or have you ever been a tobacco user? If yes... ...Describe tobacco use: _____ ...at what age did you first use tobacco: _____ ...if you have quit using tobacco, provide date: _____
7	☐ Yes ☐ No	Are you receiving workers' compensation for your cancer diagnosis?
8	☐ Yes ☐ No	Have you undergone genetic testing for cancer?

Type of cancer diagnosed:	**Date(s) of diagnosis:**

List the names and addresses of all doctors, hospitals and other health care providers who have treated your cancer diagnosis:

Health care provider	**Date of first treatment**	**Address, city, state**	**Phone**

Section N: Member affidavit for Cancer Presumption

I, the member described in section A of this *Disability Benefit Application*, who, having been duly sworn, represent that I am the person herein described, and I certify that all the statements made in Section M of this application are true and correct.

Member's signature: ▶	Date of signature:

Section O: Notary public requirement - Cancer Presumption

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 *Cancer Presumption Questionnaire* was sworn or affirmed before me and signed in my presence by the member named in the foregoing Section A, this _____ day of _____ , 20_____.

Affix Seal here	Notary's signature: ▶
	Print name:
	My commission expires: