

DISABILITY RECONSIDERATION APPLICATION and earned income statement

If you are currently receiving a less than maximum partial disability benefit from the Ohio Police & Fire Pension Fund (OP&F) and your earnings capacity has become further impaired through a deterioration of the disabling condition(s) for which you were placed on disability retirement, then you are eligible to apply for a reconsideration of your current grant. To do so, you must:

- 1: complete this application;
- 2: submit new medical evidence which substantiates your claim of increased disability.

To avoid a possible delay in processing your application, please be certain to complete all sections of this form, even if some areas are not applicable. Once the OP&F Board of Trustees' Disability Committee has reviewed these documents, it may decide that further evidence is required, order a re-examination by a physician appointed by OP&F, or render a decision to increase, decrease or to leave the initial grant unchanged.

Section A: Member information

Name: First, MI, Last, suffix (Jr. III, etc.)		Social Security Number																				
Street Address / Post office box		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> </tr> </table>																				
City, State, ZIP code		Date of Birth																				
Home phone: _____ Alternative phone: _____		Date of Retirement																				
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Section B: Disabling Medical Condition(s)

Part 1: List all medical and/or psychological conditions considered upon initial application or appeal (i.e. Left Knee injury):

Disability	Date of Onset	Cause (if known)																				
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Part 2: Name the condition(s) that have worsened since your initial application or appeal:

Disability	Date of Onset	Cause (if known)																				
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Section C: Training Program

Have you tried to enroll in any training or apprenticeship program(s)? yes no
 If yes, indicate the training program(s) in which you had enrolled as well as whether or not it was successfully completed:

Program name: _____ Successfully completed? yes no

Are you receiving Worker's Compensation? yes no

If yes, what benefits are you currently receiving:

Medical expenses Temporary total Temporary partial Permanent total Permanent partial

Are you receiving Social Security disability payments? yes no

Section D: Earned Income Report

Please state your earned income (wages, self-employed compensation, tips) in each complete tax (calendar) year since you retired. If you have been retired for more than five years, report only your earned income for the last five complete years. Also report your primary employer, job title and the duties performed.

Year	Earned Income*	Employer (list only primary employer)	Job Title	Duties Performed
20	\$			
20	\$			
20	\$			
20	\$			
20	\$			

* Do not report spouse's income, interest, dividends or income from sources other than wages, self-employed compensation, tips, etc.

Section E: Member signature and acknowledgement

I, the member described in Section A of this Disability Reconsideration Application, represent that I am the person herein described; it is my will and intent to apply for a reconsideration of 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 F: 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 Reconsideration 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: