BOARD OF TRUSTEES OF THE
AURORA POLICE PENSION FUND

Application For Disability Pension Benefits

{ Application must be completed in its entirety, dated, signed by Applicant and notarized. This Application must be filed with the Pension Board in order to initiate a claim for disability benefits. }

1. Name of Applicant: _____
2. Address: _____
3. Telephone: _____
4. Social Security Number: _____
5. Date of Birth: _____
6. Current salary: $_____ Salary on date of disability: $_____
7. Date of probationary appointment: _____
8. Date of regular appointment **and** current rank: _____
9. Identify the type of pension(s) Applicant is applying for (check as may be applicable):

   - ◉ "Line of Duty" (40 ILCS 5/3-114.1)
   - ○ "Not on Duty" (40 ILCS 5/3-114.2)
   - ○ “Heart Attack or Stroke Suffered in Performance of Duty” (40 ILCS 5/3-114.3)
   - ○ “Occupational Disease” (40 ILCS 5/3-114.6)

10. Date of removal from payroll: _____
11. Date of sickness, accident, injury or illness (referred to as the “*event*” which may have caused or contributed to the stated disability): _____
12. Date last worked full service for the Department: _____
13. Dates you worked for the Department on “light duty”:_____

14. Provide the names, addresses and telephone numbers of all person(s) who witnessed the *event*.

15. Describe, in detail, how the sickness(es), illness(es), injury(ies) or accident(s) was (were) caused (identify the location[s], date[s] and time[s]).

16. Describe fully the sickness(es), illness(es) or injury(ies) (i.e. physical or mental) of which you are complaining, and fully describe the parts of the body involved or affected.

17. Identify when, how and to whom the injury(ies) or illness(es) was (were) reported.

18. State whether you were on shift duty the day of the *event* and, if so, provide the times of your shift and the nature of your duties.

19. Provide your shift duty dates, vacation, sick and day(s) off, the week before the *event*, the week of the *event*, and the week after the *event*.

20. Provide the names, addresses and telephone numbers of all persons, firms, corporations or entities, other than this Police Department, which employed you on the date of the *event* and at any time within twelve (12) months prior to the date of the *event* (this includes self-employment).

21. State whether you know or have been advised that any individual or entity may have any documentation or tangible information concerning the incident or injury in question. If the answer to this interrogatory is affirmative, please identify fully the name of said individual or entity, his, her or its address, telephone number and the precise nature and description of the documentation or tangible information.

22. Provide the names, addresses and telephone numbers of all healthcare providers, who have treated and/or examined you respecting your sickness, accident, injury or illness in question. Healthcare providers shall include, but not be limited to; hospitals, clinics, physicians, psychiatrists, psychologists, sociologist, nurses, physician's assistant, dentist, chiropractors, laboratory technicians, physical therapists, pharmacists and any other healthcare professional or entities. Provide the dates of any such treatment and/or examination.

    PLEASE ATTACH A TYPEWRITTEN LIST OF THE ABOVE NAMES, ADDRESSES, TELEPHONE NUMBERS AND DATES OF SERVICE.

23. State whether you have been released from medical care for the injury(ies) or illness(es) for which you now claim a disability. If so, when?

24. State whether you continue to receive treatment for your injury(ies) or illness(es). If the answer is "yes", state from whom you are receiving treatment. Also state the type of treatment and how often you receive treatment.

25. State whether anyone has ever told you that your condition is "treatable". If so, identify who stated the same. Also, state the treatment required.

26. State whether anyone has ever told you that your condition is "permanent". If so, identify who stated the same. Also, state the treatment required.

27. State whether you returned to work after the injury in question. If so, when?

28. Names, addresses and telephone numbers of all persons, firms, entities or corporations against which a claim has been made in the past, is currently pending, or shall be made in the future, as the result of the "*event*" (worker's compensation, etc).

29. State whether you are you receiving benefits and/or have ever received benefits under the Workers' Compensation Act, the Workers' Occupational Diseases Act or the Public Employees Disability Act. If so, identify the name of the "Application for Adjustment of Claim", the number, and what benefits were received, are being received, or will be received:

The attached "Consent and Medical Authorization" must be completed and returned with and as a part of this Application.

If insufficient space is provided to answer any of these questions, please continue your answer on a separate sheet of paper and attach it as part of this Application, making reference to the question number.

The Applicant acknowledges that he/she has an obligation to hereinafter supplement the information requested in this Application and Request for Production, as may be required. The Applicant agrees that he/she shall supplement the above as may be required and without further request from any party or entity to comply with the same.

The Applicant acknowledges that pursuant to this Application, he/she may be required to respond to additional interrogatories and/or request for production from the Board. By his/her signature hereunder, Applicant agrees that he/she shall comply as may be required.

Under penalties of perjury, the undersigned certifies that the statements set forth in this Application and all other documents, data, and information submitted in support hereof, are true, correct, and complete.

Dated: _____ _____

Date Signature of Applicant

Subscribed and sworn to before me this _____ day of _____, 20_____.

_____

Notary Public

(This Application shall not be legally effective until such time as it is filed with the Board.)

Filed with the Board on this _____ day of _____, 20_____ at _____.

(Time)

_____

Signature of Board

PLEASE TYPE

(In reply to Item #22)

Names, addresses, telephone numbers (fax numbers, if available) and dates of treatment of all *event* healthcare providers, including, but not limited to: hospitals, clinics, physicians, psychiatrists, psychologists, sociologist, nurses, physician's assistant, dentist, chiropractors, laboratory technicians, physical therapists, pharmacists and any other healthcare professional or entities, who have treated and/or examination you respecting your sickness, accident, injury or illness in question.

State of Illinois)
) ss
County of)

CONSENT AND MEDICAL AUTHORIZATION

I, _____ (hereinafter referred to as the "Undersigned"), hereby consent as follows:

1. That the Board of Trustees of the Aurora Police Pension Fund and/or its attorney, Charles H. Atwell, 70 S. Constitution Drive, Suite 100, Aurora, Illinois 60506, be permitted to examine and obtain copies of any and all of the Undersigned's medical records, including but not limited to, the following: hospitals, doctors, psychiatrist, psychologist and medical records from any medical provider of every sort and kind; records of interviews with doctors, psychiatrist, psychologists; records of examinations, diagnosis, care, treatment and opinions.

2. That said disclosure to be made to the above-stated Board and/or its attorney, are pursuant to the Undersigned's Application filed with the Board for disability pension benefits.

3. That the Undersigned fully acknowledges that said disclosure of the records herein, are necessary in order to provide the Board with adequate knowledge of the Undersigned's medical history as the same may relate to his/her application for benefits filed before the Board.

4. The Undersigned acknowledges that his/her refusal to consent to the disclosure of his/her medical records as provided herein, may be deemed by the Board to constitute a failure of cooperation by the Undersigned and may further result in the Board being inadequately informed respecting the Undersigned's medical history and, thus, unable to render a proper determination concerning the Applicant's application for benefits.

5. **The Undersigned fully acknowledges his/her health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.**

6. The Undersigned acknowledges that he/she has the right of access to inspect and obtain a copy of his protected health information.

7. The Undersigned fully acknowledges that since the person or organization to whom this information is disclosed is not a health care provider and may be re-disclosed by the recipient, the information may no longer be protected by federal and/or state privacy law and regulations after disclosure.

8. The Undersigned acknowledges that failure to provide all required information will not constitute a proper authorization to disclose protected health information and, therefore, my request may not be honored.

9. The Undersigned acknowledges that authorizing the use or disclosure of the information identified above is voluntary and that he/she need not sign this form to ensure health care treatment, payment or eligibility for benefits.

With respect to medical records or documentation pertaining to psychological or mental injuries or illnesses, the following paragraphs shall pertain:

A. That this Consent and Medical Authorization shall continue in full force and effect through and inclusive of _____.*

B. That the Undersigned retains the right to revoke this consent at any time upon written notification provided to the attention of the Board and its attorney, return receipt required. That neither the Board nor its attorney shall assume any responsibility concerning any revocation of this Consent or any disclosures made hereunder, until each has been personally served with said statement of revocation from the Undersigned. The revocation will not apply to information that has already been released in response to this authorization.

I am willing that a Photostat of this authorization be accepted with the same authority as the original.

Dated this _____ day of _____, 20_____.

_____
Signature

_____
Address

_____
City/State/Zip Code

Subscribed and sworn to before me
this _____ day of _____,
20_____.

_____
Notary Public

*The Undersigned acknowledges that the Illinois Mental Health Confidentiality Act (740 ILCS 110/1, et seq.), provides for certain limitations respecting the duration of the Consent (A above), and provides the undersigned with the authority to revoke said consent at any time (B above). The Undersigned acknowledges that the constraints herein, imposed by the Illinois Mental Health Confidentiality Act, shall be limited solely to the disclosure of those documents defined under said statute (740 ILCS 110/1, et seq.). Thus, these limitations shall have no application to the disclosure of any medical records or other documentations which fall outside the scope of said statute or other restrictive laws.