CITY OF LAKE WORTH BEACH GENERAL EMPLOYEES' RETIREMENT SYSTEM DISABILITY APPLICANT QUESTIONNAIRE

IF YOUR CLAIM IS BASED ON AN INJURY, PLEASE ANSWER THE FOLLOWING QUESTIONS:

(If based on an illness, please go to page 8)

1. Please describe exactly how you were injured, providing specifics as to:

   a. Date.

   b. Time.

   c. Place.

   d. Provide names and addresses of all witnesses.

   e. Nature of your injury or injuries.

2. Was the injury reported to your department and if so, state the date reported and to whom.

3. Please state whether you are claiming the injury to be:

   a. Total and Permanent. [ ] Yes [ ] No

   b. Service-related. [ ] Yes [ ] No

   c. Non-service related. [ ] Yes [ ] No

   d. Provide your reasons for the above claims.

4. Please provide the names, addresses and telephone numbers of all physicians, surgeons, hospitals, chiropractors, osteopaths and other health care providers who have treated you for the condition upon which your claim is based and any condition that may be related to it.

a. Provide a brief description of what you were treated for.

b. Provide the diagnosis.

c. Provide the prognosis.

d. Provide the dates of treatment.

e. Provide the nature of treatment.

f. Provide the medications prescribed.

g. Provide the names, addresses and telephone numbers of all persons who may have knowledge of these conditions.

5. Please specifically describe any and all previous conditions that you have had, even though they may not be directly associated with the condition on which your claim is based.

a. Specifically state when you had these conditions.

b. Provide names, addresses and phone numbers of all health care providers (including chiropractors) whom you consulted or who treated you for the previous condition(s).

c. Provide the diagnosis.

d. Provide the prognosis.

e. Provide the dates of treatment.

f. Provide the nature of treatment.

g. Provide the medications prescribed.

h. Provide the names, addresses and telephone numbers of all persons who may have knowledge of such condition.

6. Have you ever been involved in an automobile or other vehicular accident? If so, please provide:

a. When the accident occurred.

b. Where the accident occurred.

c. How the accident occurred.

d. Whether you were injured.

e. How you were injured.

f. Was this accident job related?

g. Names, addresses and telephone numbers of all health care providers who treated you.

h. Diagnosis.

i. Prognosis.

j. Medications prescribed.

k. Nature of treatment.

l. Dates of treatment.

m. Provide the names, addresses and telephone numbers of all who may have knowledge of the injuries resulting from the accident.

7. Have you ever had a fall, collision, sports injury, accident, etc. which required treatment by a health care provider? If so, please provide:

a. A description of the incident.

b. When it occurred.

c. How it occurred.

d. Where it occurred.

e. How you were injured.

f. Names, addresses and telephone numbers of all health care providers who treated you.

g. Diagnosis.

h. Prognosis.

i. Medications prescribed.

j. Nature of treatment.

k. Dates of treatment.

l. Provide the names, addresses and telephone numbers of all persons who may have knowledge of the injuries resulting from the incident.

8. Please provide the names, addresses and dates of all your prior and current employers, and provide:

a. The nature of the work involved with each employment.

b. The status (i.e. terminated, continuing, etc.) of each employment.

c. State the basis or reason for such status.

9. Please state whether you are now or ever have been self employed, and if so, state the nature of the work.

10. Were you suffering any injury, disease, or disability at the time of the accident(s), incident(s), or condition(s) for which you are now applying for disability retirement? If so, what was the nature of the injury, disease or disability?

11. Describe all records of the accident(s) or incident(s) forming the basis of your application for disability retirement, including but not limited to, traffic accident reports, police reports, notice of injury reports, log books, hospital/clinic records, doctor's records, disciplinary records, etc.

12. Provide the name and addresses of all health care providers who have advised you that you are permanently and totally incapable of performing useful and efficient service, either physically or mentally, as a ____________________ (specify job description) as a result of the injury or condition for which you seek disability retirement.

13. Provide the name and addresses of all health care providers who have advised you that you are not permanently and totally incapable of performing useful and efficient service, either physically or mentally, as a ____________________ (specify job description) as a result of the injury or condition for which you seek disability retirement.

14. State the date on which you reached maximum medical improvement (MMI) for workers' compensation purposes, and provide the names and addresses of all health care providers who have advised that you have reached maximum medical improvement (MMI).

15. Provide the names and addresses of all health care providers who have advised that you have not reached maximum medical improvement (MMI).

16. Is the injury which you are now claiming permanently and totally prevents you, physically or mentally, from performing useful and efficient service as a _____________ (specify job description) in any way related to any other injury, disease, condition or disability? If yes, explain.

17. Has your sworn statement or deposition ever been taken in connection with any claim arising out of the injury or disability for which you seek disability retirement? If so, state the date taken and by whom.

18. Is there any other information known to you, your agents and attorneys, which might be relevant to your application for disability retirement? If so, specify.

19. Have you ever applied for worker's compensation benefits in any jurisdiction? If so, please state for each application:

a. The name and address of the employer.

b. The date of the application.

c. Determination of the application.

d. The dates of receipt of benefits.

20. Describe in detail why you feel that you are permanently and totally unable physically or mentally, from performing useful and efficient service as a ____________________ (specify job description).

**** Please go to Page 13, read and sign the acknowledgment.**

* * * * * * * * * *

IF YOUR CLAIM IS BASED ON AN ILLNESS,
PLEASE ANSWER THE FOLLOWING QUESTIONS

21. Please describe the nature of your illness and how you became ill, providing specifics as to date, time and place, and providing names and addresses of all witnesses (if applicable).

22. Please state whether you are claiming the illness to be:

a. Total and permanent [ ]

b. Service-related [ ]

c. Non-service related [ ]

d. Provide your reasons for the above claims.

23. Please provide the names, addresses and telephone numbers of all physicians, surgeons, hospitals, chiropractors, osteopaths and other health care providers who have treated you for the condition upon which your claim is based and any condition that may be related to it.

a. Provide a brief description of what you were treated for.

b. Provide the diagnosis.

c. Provide the prognosis.

d. Provide the dates of treatment.

e. Provide the nature of treatment.

f. Provide the medications prescribed.

g. Provide the names, addresses and telephone numbers of all persons who may have knowledge of these conditions.

24. Please specifically describe any and all previous conditions that you have had, even though they may not be directly associated with the condition on which your claim is based.

a. Specifically state when you had these conditions.

b. Provide names, addresses and phone numbers of <u>all</u> health care providers (including chiropractors) whom you consulted or who treated you for the previous condition(s).

c. Provide the diagnosis.

d. Provide the prognosis.

e. Provide the dates of treatment.

f. Provide the nature of treatment.

g. Provide the medications prescribed.

h. Provide the names, addresses and telephone numbers of <u>all</u> persons who may have knowledge of such condition.

25. Were you suffering any injury, disease, or disability at the time of the accident(s), incident(s), or condition(s) for which you are now applying for disability retirement? If so, what was the nature of the injury, disease or disability?

26. Provide the name and address of all health care providers who have advised you that you are permanently and totally incapable of performing useful and efficient service, either physically or mentally, as a ______________________ (specify job description) as a result of the disease or disability for which you seek disability retirement.

27. Provide the names and addresses of all health care providers who have advised you that you are not permanently and totally incapable of performing useful and efficient service, either physically or mentally, as a _____________________ (specify job description) as a result of the injury or condition for which you seek disability retirement.

28. State the date on which you reached maximum medical improvement (MMI) for workers' compensation purposes, and provide the names and addresses of all doctors who have advised that you have reached maximum medical improvement (MMI).

29. Provide the names and addresses of all health care providers who have advised that you have not reached maximum medical improvement (MMI).

30. Please provide the names, addresses and dates of all of your prior and current employers, and provide:

a. The nature of the work involved with each employment.

b. The status (i.e. terminated, continuing, etc.) of each employment.

c. State the basis or reason for such status.

31. Please state whether you are now or ever have been self employed, and if so, state the nature of the work.

32. Is the disease or disability which you are now claiming permanently and totally prevent you, physically or mentally, from performing useful and efficient service as a ______________________ (specify job description) in any way related to any other injury, disease, condition or disability? If yes, explain.

33. Describe in detail why you feel that you are permanently and totally unable physically or mentally, from performing useful and efficient service as a ______________ ___________ (please state your job title/description).

34. Has your sworn statement or deposition ever been taken in connection with any claim arising out of the disease or disability for which you seek disability retirement? If so, state the date taken and by whom.

35. Is there any other information known to you, your agents and attorneys, which might be relevant to your application for disability retirement? If so, specify.

YOU ARE REQUIRED TO SUPPLEMENT THIS QUESTIONNAIRE IMMEDIATELY IN WRITING TO THE PLAN'S ADMINISTRATOR WITH ANY NEW OR ADDITIONAL INFORMATION OBTAINED BETWEEN THE TIME OF SIGNING THIS QUESTIONNAIRE AND FINAL DECISION BY THE BOARD OF TRUSTEES.

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED HEREIN IS TRUE AND COMPLETE. I UNDERSTAND THAT IT IS A CRIME FOR A PERSON WILLFULLY AND KNOWINGLY TO MAKE, OR CAUSE TO BE MADE, OR TO ASSIST, CONSPIRE WITH, OR URGE ANOTHER TO MAKE, OR CAUSE TO BE MADE, ANY FALSE, FRAUDULENT, OR MISLEADING ORAL OR WRITTEN STATEMENT OR WITHHOLD OR CONCEAL MATERIAL INFORMATION TO OBTAIN ANY BENEFIT AVAILABLE UNDER THE PENSION PLAN. IN ADDITION TO ANY APPLICABLE CRIMINAL PENALTY UPON CONVICTION FOR A VIOLATION DESCRIBED ABOVE, I MAY IN THE DISCRETION OF THE BOARD OF TRUSTEES, BE REQUIRED TO FORFEIT THE RIGHT TO RECEIVE ANY OR ALL BENEFITS TO WHICH I WOULD OTHERWISE BE ENTITLED. FOR PURPOSES HEREOF, "CONVICTION" MEANS A DETERMINATION OF GUILT THAT IS THE RESULT OF A PLEA OR TRIAL, REGARDLESS OF WHETHER ADJUDICATION IS WITHHELD.

DATED this ______ day of ____________________, 20___.

____
Applicant's Signature

Print Name:____________________________