ST. LUCIE COUNTY FIRE DISTRICT
FIREFIGHTERS' PENSION TRUST FUND
APPLICATION FOR DISABILITY PENSION BENEFITS

PLEASE PRINT OR TYPE

1. a. Name of Employee: _____
(Last) (First) (MI)

b. Social Security Number: _____

c. Date of Birth: _____ (Attach proof)
Month-Day-Year

d. Home Telephone Number: _____
(Area Code) Number

e. Home Address: _____
Address Street

_____
Town State Zip Code

f. Permanent address to which check and/or correspondence should be sent:

_____
Street Address

_____
Town State Zip Code

2. a. Are you currently married: _____Yes _____No

If yes, please complete the following:

I. Name of Spouse: _____
(Last) (First) (MI)

ii. Spouse's Social Security Number: _____

iii. Spouse's Date of Birth: _____ (Attach proof)
Month-Day-Year

iv. Date of Marriage: _____ (Attach proof)
Month-Day-Year

3. Names and Dates of Birth of Child(ren):

Name	Date of Birth
_____	_____
_____	_____
_____	_____

(Attach additional page if needed)

4. Names of Your Living Parents:

   a. Mother: _____

   b. Father: _____

5. a. Date of Hire by the St. Lucie County Fire District, as a certified Firefighter:

   _____
   Month-Day-Year

   b. Current Position: _____

6. I plan to retire on: _____
   Month-Day-Year

7. Type of disability retirement for which you are applying (check one):

   _____ Line-of-Duty Disability

   _____ Non-Line-of-Duty Disability

8. Please complete the following related to your disability:

   a. Date disability commenced: _____
   Month-Day-Year

   b. Nature and cause of disability: _____

   _____

   _____

c. Did your disability result from any of the following:

		Yes	No
(1)	Use of drugs, intoxicants or narcotics?	_____	_____
(2)	Due to a fight, riot, civil insurrection, or crime?	_____	_____
(3)	From an injury or disease sustained while you were serving in any armed forces?	_____	_____
(4)	After your employment with the St. Lucie County Fire District terminated?	_____	_____
d.	A copy of my doctor's medical opinion is attached.	_____	_____

e. Please list any doctor's that have treated you within the last five years and their address and phone number on a separate sheet of paper.

_____

f. Please indicate the name and address of the physician treating you for the disability listed in 8b:

_____

_____

_____

NOTE: When applying for a disability benefit, records must be filed to show that the disability is total and permanent. If application is made for a line-of-duty disability, copies of workers' compensation records must also be filed. Also, the Board of Trustees may require you to be examined by a doctor selected by the Board.

NOTICE: It is a first degree misdemeanor to make a false or misleading statements to obtain retirement benefits. In addition to any applicable criminal penalty, upon conviction a participant or beneficiary of this plan may, in the discretion of the board of trustees, be required to forfeit the right to receive any or all benefits to which the person would otherwise be entitled under this plan.

Acknowledgments

I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me for benefits.

I have reviewed the Designation of Beneficiary Form filed with the Board of Trustees and I hereby certify its accuracy. If I desire to change my designated beneficiary(ies), I will file a new Designation of Beneficiary Form with this Application.

I hereby authorize the release of any and all medical records including but not limited to the complete history records in possession of all doctors listed below concerning my illness and/or treatment. A copy of this document will be treated in the same manner and have the same effect as an original.

I hereby waive my right of confidentiality of my medical records and other medical evidence in order that my application for disability benefits may be properly processed. I understand that in so doing, such records will be discussed during one or more public meetings and will become public record. I understand that the Board(s) will rely upon this waiver and that I will not be able to withdraw same at a later date.

I agree to cooperate fully with the Board of Trustees of the St. Lucie County Fire District Firefighters' Pension Fund in making available to the Board, or authorized agents of the Board, information which reasonably relates to the initial payment of or continuing eligibility for payment of benefits from the Fund, including the responsibility to update the Board as to my receipt of workers' compensation payments or settlements.

I hereby agree to indemnify and hold harmless the St. Lucie County Fire District and the Pension Trust Fund from and against any and all claims, demands, or causes of action of any kind or nature resulting from or in connection with the St. Lucie County Fire District's release of the results of the undersigned's medical records to the Pension Plan and from and against any resulting losses, costs, expenses, reasonable attorneys' fees, liabilities, damages, orders, judgments, or decrees in connection therewith.

Dated this _____ day of, _____, 20_____.

_____ _____
Witness Signature of Participant

_____ _____
Witness Printed name of Participant

STATE OF FLORIDA
COUNTY OF _____

SWORN TO (or AFFIRMED) AND SUBSCRIBED before me this ___ day of _____ ,

20___, by _____ who is: _____ Personally known ***- OR who***

Produced identification: _____
Type of identification produced

_____ _____
Signature of Notary ***Print, type or stamp name of Notary in addition to seal***
[Affix Notary Seal]