CITY OF DES PLAINES FIREFIGHTERS' PENSION FUND
APPLICATION FOR DISABILITY BENEFITS

Name: _____
Address: _____
_____
E-mail: _____
D/O/B: _____

Date of Probationary Appointment: _____
Date of Regular Appointment: _____
Current Rank: _____

I hereby make application for the following type(s) of disability pension (please check all that apply):

_____ Line of duty disability (40 ILCS 5/4-110)
_____ Not on duty disability (40 ILCS 5/4-111)
_____ Occupation disease disability (40 ILCS 5/4-110.1)

Date last worked: _____
Date removed from payroll (if applicable): _____
Current Pay Status (none, full salary/PEDA, TTD): _____
Do you currently remain employed with the City of Des Plaines? Yes [ ] / No [ ]

INFORMATION CONCERNING INJURY/CONDITION

Date of sickness/accident/injury: _____
Location(s) of event: _____

Please describe, in detail, the nature of *any and all known* and/or alleged disabilities/illnesses/conditions which you are basing this claim upon. You *must list* any and all alleged injuries/illnesses/conditions that you claim to be disabled from and aware of as of the date of this application. Failure to do so shall constitute a waiver of your right to amend this application to provide for such additional claims of relief at a later date in time. You must include a detailed narrative/chronology of events which lead to the onset of your condition as well as a description & chronology of your symptoms. You must also include a description as to how your claimed disabilities/illnesses/conditions render you disabled from service. (Feel free to attach additional sheets of paper):

_____
_____
_____
_____
_____
_____
_____
_____

Please list any and all witnesses to the incident(s) which gave rise to your claimed disability. Be sure to include contact information for each:

MEDICAL HISTORY

Do you have any pre-existing condition(s) related to the condition(s) you claim to be disabled from? Yes [ ] / No [ ]

Have you suffered from the same condition / sustained any injuries to the same body part you claim to be disabled from? Yes [ ] / No [ ]

If yes to either, please list the name of the facility, address and phone number where you were treated and the date(s)/type(s) of evaluation & treatment.

NAME	ADDRESS/PHONE	DATE(S)/TYPE OF EVALUATION(S)

MEDICAL TREATMENT/EVALUATION

Under the Illinois Pension Code, you are required to be evaluated by three (3) examining physicians. *See,* 40 ILCS 5/4-112. In order to facilitate these examinations, the Fund must obtain your medical records from all health care providers who have treated you for your disability. Thus, we kindly request that you provide us with detailed and accurate information concerning your medical history. This information, coupled with your execution of the Board's medical authorization(s) will assist in our procurement of your medical records. Please note that only until the Board has obtained a complete copy of your records can it proceed with the adjudication of this application. This process may take several months to complete.

Please list any/all physician(s) or health care provider(s) who have examined or treated you regarding this disability (feel free to attach separate list, if necessary):

NAME	ADDRESS/PHONE	DATE(S) OF EXAMINATION

Please list your personal physician(s) or other health care provider(s):

NAME	ADDRESS/PHONE	DATE(S) OF EXAMINATION

Please list any special treatment(s) (including surgeries) that you have had in regard to this disability.

TREATMENT/SURGERY	DATE	NAME OF PHYSICIAN

Have you had physical therapy with regard to your disability? Yes [ ] / No [ ]

If yes, please list the name of your physical therapist(s), and the date(s) of service:

NAME	ADDRESS/PHONE	DATE(S) OF THERAPY

Have you had a functional capacity evaluation (FCE)? Yes [ ] / No [ ]

Have you undergone an MRI? Yes [ ] / No [ ]

Were X-Ray(s) taken? Yes [ ] / No [ ]

Have you undergone any other sort of specialized examination with regard to this disability? Yes [ ] / No [ ]

If yes, please list the name of the facility, address and phone number where you were tested and the date of evaluation.

NAME	ADDRESS/PHONE	DATE(S)/TYPE OF EVALUATION(S)

OUTSIDE EMPLOYMENT

Please list the names and addresses of any outside current employer(s) and/or previous employer(s) for the last five (5) years:

NAME	ADDRESS/PHONE	JOB DESCRIPTION

Please provide a description of your job duties for each outside employment you have engaged in (feel free to attach additional sheets if necessary):

Have you ever suffered any injury/accident related to your outside employment that caused or contributed to your disability? Yes [ ] / No [ ]

If yes, please describe the incident or injury, including a chronology of events which lead to the injury as well as a list of any treatment you received in response to the injury (feel free to attach additional sheets if necessary):

OUTSIDE ACTIVITIES

Please list/describe any physical activities, hobbies, sports, etc. that you participate in or have participated in over the past five (5) years leading up to your alleged disability:

WORKER'S COMPENSATION

Have you filed a worker's compensation claim in connection with your claimed disability?
Yes [ ] / No [ ]

If yes, please provide the date(s) of filing and case number(s):

LEGAL REPRESENTATION IN THIS CLAIM

Do you have an attorney representing you in your disability application?
Yes [ ] / No [ ]

If yes, please provide the attorney's contact information (including website/e-mail address)

I, _____, hereby certify that the information contained herein is accurate & complete to the best of my recollection.

In support of this application, I fully consent to the release of the following to the Board of Trustees of the Des Plaines Fire Pension Fund and its attorneys: (1) any and all medical records prepared during the physical examination I was required to undergo for employment with the Des Plaines Fire Department or application with the Des Plaines Fire Department; (2) any examination by physician(s) or physical therapist(s) I listed above; (3) any medical test results or examination(s) by any physician or physical therapist which is relevant to the application I am making; (4) any relevant employment records from the Des Plaines Fire Department or any employer I have listed above; (5) any and all relevant records relating to any worker's compensation claims that I have filed; and (6) any other additional relevant records from any source that may be relevant to this application, including functional capacity evaluation reports, psychological evaluations/reports, and independent medical examinations. _____ (initial)

I also understand that I must complete and sign an authorization for release of health information which is attached to this application, that a photocopy of the authorization shall be as effective as the original and that additional medical releases may need to be executed by me in order to process my disability claim. _____ (initial)

Furthermore, I hereby agree to fully cooperate with the Pension Board's scheduling of my independent medical examinations & hearing on this claim. Should I need to reschedule any given examination, I hereby agree to notify the Pension Board's attorney at least five (5) business days prior to the date of my scheduled examination. Should I fail to provide such timely notice, I hereby agree to personally assume all cost(s) associated with such cancellation._____ (initial)

I hereby ____consent / ____ do not consent (mark one) to the Pension Board and/or its legal counsel's utilization of my e-mail address listed on page one of this application for purposes of providing me with notice of intended action and updating me as to the status of my claim.

I hereby acknowledge that the Pension Board maintains Administrative Rules & Regulations pertaining to disability claims and adjudications, that they shall apply to my claim, and that I have the right to procure a copy of the same for inspection. _____ (initial)

Social Security Number	Signature of Applicant
Address	Print Name
City, State & Zip Code	Telephone
Date	Date of Birth