**CITY OF DES PLAINES FIREFIGHTERS' PENSION FUND**
**AFFIDAVIT OF ELIGIBILITY – DISABILITY PENSION ANNUAL EXAMINATION**

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**Pursuant to 40 ILCS 5/4-112, the following affidavit must be completed and returned in the enclosed envelope within twenty (20) days to ensure that your next payment will be issued in a timely fashion. The form must be signed in the presence of a Notary Public and notarized, or it will NOT be accepted upon return.**

Name:_____ Phone:_____

Address:_____ Date of Birth:_____

_____ Your SSN:_____

Spouse's Name:_____ Spouse's SSN:_____

Current Employer:_____ Employer's Phone No.:_____

Address:_____ Job Title:_____

**Check the appropriate items:**

1. I am now receiving a:
   - ☐ Line of Duty Disability Pension
   - ☐ Not on Duty Disability Pension
   - ☐ Heart Attack / Stroke Disability Pension
   - ☐ Occupational Disease Disability Pension

2. I am currently:
   - ☐ Single
   - ☐ Married
   - ☐ Divorced

3. If you have remarried, what was the date of your remarriage?_____

4. Do you have dependent children or dependent parents?_____

5. If yes, please give names, dates of birth, and Social Security Numbers:_____
   _____

**You MUST attach a completed "Consent and Medical Authorization" for the release of your relevant medical records, if any, and answer all of the following questions:**

**Current treating physicians or other medical professionals:**

| NAME | ADDRESS/PHONE | DATE OF MOST RECENT EXAM/TREATMENT |
|---|---|---|
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**Have you had any treatment(s) and/or surgery(s) in regards to your disability since the date of your last pension related medical evaluation?**

Yes ☐ or No ☐ If YES, please list treatment/surgery, date, and treating physician/medical provider:

| Treatment/Surgery | Date | Treating Physician/Medical Provider Name, Address, and Phone Number |
|---|---|---|
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**Have you had any physical therapy in regards to your disability since the date of your last pension related medical evaluation?**

Yes ☐ or No ☐ If YES, please list physical therapist, date, and physical therapist address and phone number:

| Physical Therapist | Date | Physical Therapist Address and Phone Number |
|---|---|---|
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Please describe any physical activities in which you regularly engage:_____

**I CERTIFY THAT THE ABOVE INFORMATION AND STATEMENTS ARE TRUE.**

_____ _____

Signature of Pensioner Date

Subscribed and Sworn to
before me this ____day of
_____, 20____

_____
NOTARY PUBLIC

**FOR BOARD USE ONLY**

**Received by:** _____

**Signature:** _____

**Date:** _____