Clear Form

Oklahoma Municipal Retirement Fund

APPLICATION FOR DISABILITY RETIREMENT PENSION
DB 4.30

PERSONAL INFORMATION (Please print clearly using black or blue ink)

NAME OF PLAN: *(Employer)* _____

NAME: _____
(First) (Middle) (Last) (Suffix)

SOCIAL SECURITY NUMBER: _____ **DATE OF BIRTH*:** _____ **GENDER:** _____
* Proper evidence must be submitted to verify age

EMPLOYEMENT DATE: _____

SERVICE CREDIT DATE: _____ **LAST DAY OF EMPLOYMENT:** _____

PRIMARY PHONE: _____ **EMAIL ADDRESS:** _____

MAILING ADDRESS: _____
(PO Box or Number and Street) (City, State and Zip Code)

PRIOR SERVICE: Have you been employed by another Municipality covered under OkMRF? ☐ No ☐ Yes

If yes, where: _____

INSTRUCTIONS

Use this form to apply for Disability Retirement Pension.
Participant needs to:

1. Complete Personal Information and Sections 1, 2, 3, 5 and attached Form W-4P.
2. Have your Physician complete Section 7.
3. Return Form DB 4.30 to your Employer.

Employer needs to:

1. Complete Section 6.
2. Present Application and physician/municipality evidence to your governing body for consideration.
3. Complete Section 4 to approve or deny Disability Pension.
4. Return Sections 1 through 4, Form W-4P ONLY to OkMRF offices and attach a copy of the minutes.
5. Detach Sections 5 through 7 and retain for your records.

City to submit pages 1 through 3 to:
VIA MAIL Oklahoma Municipal Retirement Fund
1001 NW 63rd Street, Suite 260
Oklahoma City, OK 73116

Questions? (888) 394-6673, ext. 104 or 109
VIA FAX* Oklahoma Municipal Retirement Fund
(405) 606-7879
* If faxing form please follow-up by sending original via mail.

SECTION 1. DISABILITY INFORMATION

NATURE/CAUSE OF DISABILITY: _____

TYPE OF DISABILITY: ☐ **INJURY** **DATE INJURY OCCURRED:** _____
☐ **ILLNESS** **DATE SYMPTOMS FIRST OBSERVED:** _____

IF ILLNESS, HAVE YOU BEEN PREVIOUSLY DISABLED? _____ **HOW LONG?** _____

DOES INJURY/ILLNESS PREVENT YOU FROM ENGAGING IN ANY GAINFUL EMPLOYEMENT? ☐ **YES** ☐ **NO**

IF NO, WHAT TYPE OF WORK COULD YOU DO? _____

LIST ALL LICENSED AND PRACTICING PHYSICIANS SEEN FOR DISABILITY

NAME: _____

ADDRESS: _____
(Number and Street) (City, State and Zip Code)

NAME: _____

ADDRESS: _____
(Number and Street) (City, State and Zip Code)

Participant to complete

SECTION 2. PARTICIPANT CERTIFICATION

In accordance with the provisions of the Retirement Plan, I hereby apply for a Disability Retirement pension, for which I believe I have met the eligibility requirements. I submit the following information for the purpose of obtaining such pension, and hereby certify that it is true and correct to the best of my knowledge and belief. **I certify that:**

(a) I am less than 65 years of age;
(b) I am unable to perform the duties of any assigned position in the municipality that employs me; and
(c) I have not concealed any material fact.

I understand that, in accordance with the Plan:

(1) I shall not qualify for a Disability Pension if the Committee determines that my Disability results from (a) chronic alcoholism, (b) addiction to narcotics, (c) an injury suffered while engaged in felonious or criminal act or enterprise, or (d) service in the armed forces of the United States which entitles the Employee to a veteran's disability pension; and
(2) My disability shall be considered to have ended and a Disability Pension shall cease if, prior to my Normal Retirement Age, I (a) engage in any substantial gainful employment except for such employment as is found by the Committee to be for the primary purpose of rehabilitation or not incompatible with a finding of total and permanent Disability, or (b) have sufficiently recovered, in the opinion of the Committee based on a medical examination by a doctor or clinic appointed by the Committee, to be able to engage in regular employment with the Employer and refuse an offer of employment by the Employer, or (c) refuse to undergo any medical examination requested by the Committee provided that a medical examination shall not be required more frequently than twice in any calendar year.

Release of Information:

I hereby authorize any doctor, practitioner, hospital or sanitarium to give the Retirement Committee any information if requested about me with reference to any treatments, advice or hospitalization and I agree to execute the appropriate release forms for my medical records.

_____ _____
Date **Participant's Signature**

If your plan included the Defined Contribution Hybrid Option, complete Form DB 4.10 for a Hybrid Account Distribution.

SECTION 3. STATE TAX WITHHOLDING ELECTION

RECURRING PAYMENTS – State Income Tax Withholding

As a benefit recipient, the following withholding alternatives are available to you.

OPTION 1: You may specify that you do not want any state income tax deducted from your benefit.

OPTION 2: Complete the marital status and number of allowances. If Option 2 is elected, the tax withholding may or may not meet your required amounts. You may withhold an additional monthly amount which will be added to the IRS tax withholding tables.

In requesting the distribution of my funds from OkMRF, I designate the following election*: (check ONE)
*We will withhold based on your current state of residence unless you specify differently here _____ .

OPTION 1 ☐ No withholding for Oklahoma income tax.

OPTION 2 ☐ Complete below to withhold based on Oklahoma tax withholding tables.
☐ Single ☐ Married ☐ Married – but withhold at higher single rate
_____ Number of withholding allowances you want to claim (if blank OkMRF will assume 0).
Additional amount in whole dollars, if any, you want withheld from each monthly payment $_____ .

FEDERAL TAX WITHHOLDING ELECTION

REQUIRED: Please complete either Form W-4P on the following pages.

Form **W-4P**

Department of the Treasury
Internal Revenue Service

Withholding Certificate for Periodic Pension or Annuity Payments

Give Form W-4P to the payer of your pension or annuity payments.

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number

Address

City or town, state, and ZIP code

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to receive your payments only part of the year; or have changes during the year in your marital status, number of pensions/jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs or pension/annuity payments), deductions, or credits. Have your most recent payment statements/pay stubs from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See pages 2 and 3 for more information on each step, when to use the estimator at *www.irs.gov/W4App*, and how to elect to have no federal income tax withheld (if permitted).

Step 2: Income From a Job and/or Multiple Pensions/ Annuities (Including a Spouse's Job/ Pension/ Annuity)

Complete this step if you (1) have income from a job or more than one pension/annuity, or (2) are married filing jointly and your spouse receives income from a job or a pension/annuity. **See page 2 for examples on how to complete Step 2.**

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Complete the items below.

(i) If you (and/or your spouse) have one or more jobs, then enter the total taxable annual pay from all jobs, plus any income entered on Form W-4, Step 4(a), for the jobs less the deductions entered on Form W-4, Step 4(b), for the jobs. Otherwise, enter "-0-" . . . $

(ii) If you (and/or your spouse) have any other pensions/annuities that pay less annually than this pension/annuity, then enter the total annual taxable payments from all lower-paying pensions/annuities. Otherwise, enter "-0-" . . . . . $

(iii) Add the amounts from items (i) and (ii) and enter the **total** here . . . . . $

TIP: To be accurate, submit a new Form W-4P for all other pensions/annuities if you haven't updated your withholding since 2021 or this is a new pension/annuity that pays less than the other(s). Submit a new Form W-4 for your job(s) if you have not updated your withholding since 2019.

Complete Steps 3–4(b) on this form only if (b)(i) is blank **and** this pension/annuity pays the most annually. Otherwise, do not complete Steps 3–4(b) on this form.

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $

Multiply the number of other dependents by $500 . . . . . $

Add other credits, such as foreign tax credit and education tax credits $

Add the amounts for qualifying children, other dependents, and other credits and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs or pension/annuity payments). If you want tax withheld on other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, taxable social security, and dividends . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the basic standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld from **each payment** . **4(c)** $

Step 5: Sign Here

Your signature (This form is not valid unless you sign it.) **Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about any future developments related to Form W-4P, such as legislation enacted after it was published, go to *www.irs.gov/FormW4P*.

Purpose of form. Complete Form W-4P to have payers withhold the correct amount of federal income tax from your periodic pension, annuity (including commercial annuities), profit-sharing and stock bonus plan, or IRA payments. Federal income tax withholding applies to the taxable part of these payments. Periodic payments are made in installments at regular intervals (for example, annually, quarterly, or monthly) over a period of more than 1 year. Don't use Form W-4P for a nonperiodic payment (note that distributions from an IRA that are payable on demand are treated as nonperiodic payments) or an eligible rollover distribution (including a lump-sum pension payment). Instead, use Form W-4R, Withholding Certificate for Nonperiodic Payments and Eligible Rollover Distributions, for these payments/distributions. For more information on withholding, see Pub. 505, Tax Withholding and Estimated Tax.

Choosing not to have income tax withheld. You can choose not to have federal income tax withheld from your payments by writing "No Withholding" on Form W-4P in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Generally, if you are a U.S. citizen or a resident alien, you are not permitted to elect not to have federal income tax withheld on payments to be delivered outside the United States and its territories.

Caution: If you have too little tax withheld, you will generally owe tax when you file your tax return and may owe a penalty unless you make timely payments of estimated tax. If too much tax is withheld, you will generally be due a refund when you file your tax return. If your tax situation changes, or you chose not to have federal income tax withheld and you now want withholding, you should submit a new Form W-4P.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Are submitting this form after the beginning of the year;

2. Have social security, dividend, capital gain, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax;

3. Receive these payments or pension and annuity payments for only part of the year; or

4. Have changes during the year in your marital status, number of pensions/jobs for you (and/or your spouse if married filing jointly), number of dependents, or changes in your deductions or credits.

TIP: Have your most recent payment statements/pay stubs from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you (or you and your spouse) receive. If you do not have a job and want to pay these taxes through withholding from your payments, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

Payments to nonresident aliens and foreign estates. Do not use Form W-4P. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities, and Pub. 519, U.S. Tax Guide for Aliens, for more information.

Tax relief for victims of terrorist attacks. If your disability payments for injuries incurred as a direct result of a terrorist attack are not taxable, write "No Withholding" in the space below Step 4(c). See Pub. 3920, Tax Relief for Victims of Terrorist Attacks, for more details.

Specific Instructions

Submit a **separate Form W-4P** for each pension, annuity, or other periodic payments you receive.

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you have at least one of the following: income from a job, income from more than one pension/annuity, and/or a spouse (if married filing jointly) that receives income from a job/pension/annuity. The following examples will assist you in completing Step 2(b).

Example 1. Taylor, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Taylor also has a job that pays $25,000 a year. Taylor has no other pensions or annuities. Taylor will enter $25,000 in Step 2(b)(i) and in Step 2(b)(iii).

If Taylor also has $1,000 of interest income, which they entered on Form W-4, Step 4(a), then they will instead enter $26,000 in Step 2(b)(i) and in Step 2(b)(iii). They will make no entries in Step 4(a) on this Form W-4P.

Example 2. Casey, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Casey does not have a job, but receives another pension for $25,000 a year (which pays less annually than the $50,000 pension). Casey will enter $25,000 in Step 2(b)(ii) and in Step 2(b)(iii).

If Casey also has $1,000 of interest income, then they will enter $1,000 in Step 4(a) of this Form W-4P.

Example 3. Sam, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Sam does not have a job, but receives another pension for $75,000 a year (which pays more annually than the $50,000 pension). Sam will not enter any amounts in Step 2.

If Sam also has $1,000 of interest income, they won't enter that amount on this Form W-4P because they entered the $1,000 on the Form W-4P for the higher paying $75,000 pension.

Example 4. Alex, a single filer, is completing Form W-4P for a pension that pays $50,000 a year. Alex also has a job that pays $25,000 a year and another pension that pays $20,000 a year. Alex will enter $25,000 in Step 2(b)(i), $20,000 in Step 2(b)(ii), and $45,000 in Step 2(b)(iii).

If Alex also has $1,000 of interest income, which they entered on Form W-4, Step 4(a), they will instead enter $26,000 in Step 2(b)(i), leave Step 2(b)(ii) unchanged, and enter $46,000 in Step 2(b)(iii). They will make no entries in Step 4(a) of this Form W-4P.

If you are married filing jointly, the entries described above do not change if your spouse is the one who has the job or the other pension/annuity instead of you.

CAUTION ***Multiple sources of pensions/annuities or jobs.*** *If you (or if married filing jointly, you and/or your spouse) have a job(s), do NOT complete Steps 3 through 4(b) on Form W-4P. Instead, complete Steps 3 through 4(b) on the Form W-4 for the job. If you (or if married filing jointly, you and your spouse) do not have a job, complete Steps 3 through 4(b) on Form W-4P for* ***only*** *the pension/annuity that pays the most annually. Leave those steps blank for the other pensions/annuities.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible

Specific Instructions *(continued)*

in this step, such as the foreign tax credit and the education tax credits. Including these credits will increase your payments and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include amounts from any job(s) or pension/annuity payments. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your pension, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 6, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes itemized deductions, the additional standard deduction for those 65 and over, and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from **each payment**. Entering an amount here will reduce your payments and will either increase your refund or reduce any amount of tax that you owe.

Note: If you don't give Form W-4P to your payer, you don't provide an SSN, or the IRS notifies the payer that you gave an incorrect SSN, then the payer will withhold tax from your payments as if your filing status is single with no adjustments in Steps 2 through 4. For payments that began before 2025, your current withholding election (or your default rate) remains in effect unless you submit a new Form W-4P.

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1	Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income	**1**	$
2	Enter: • $30,000 if you're married filing jointly or a qualifying surviving spouse • $22,500 if you're head of household • $15,000 if you're single or married filing separately	**2**	$
3	If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-"	**3**	$
4	If line 3 equals zero, and you (or your spouse) are 65 or older, enter: • $2,000 if you're single or head of household. • $1,600 if you're married filing separately. • $1,600 if you're a qualifying surviving spouse or you're married filing jointly and one of you is under age 65. • $3,200 if you're married filing jointly and both of you are age 65 or older. Otherwise, enter "-0-". See Pub. 505 for more information	**4**	$
5	Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information	**5**	$
6	**Add** lines 3 through 5. Enter the result here and in **Step 4(b)** on Form W-4P	**6**	$

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. You are required to provide this information only if you want to (a) request federal income tax withholding from pension or annuity payments based on your filing status and adjustments; (b) request additional federal income tax withholding from your pension or annuity payments; (c) choose not to have federal income tax withheld, when permitted; or (d) change a previous Form W-4P. To do any of the aforementioned, you are required by sections 3405(e) and 6109 and their regulations to provide the information requested on this form. Failure to provide this information may result in inaccurate withholding on your payment(s). Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Page intentionally left blank for two-sided printing.

Employer to complete

SECTION 4. EMPLOYER CERTIFICATION AND APPROVAL

NAME OF PLAN: _____

NAME OF EMPLOYEE: _____ **SOCIAL SECURITY NO:** _____

HIRE DATE: _____ **SERVICE CREDIT DATE:** _____ **LAST DAY WORKED:** _____

Based on the evidence and documentation provided, the Employer submits the following authorization for Disability Retirement Pension:

By signing below, the Authorized Agent confirms that each of the following statements is true and correct:

PAYROLL INFORMATION

A) Final salary amount to be submitted $ _____ , to be paid on _____

B) I confirm that:
   1) I have reviewed the Salary History for this Participant on the OkMRF website and confirmed it to be true and accurate; and
   2) OkMRF is authorized to proceed with the benefit calculation based on this data.

CERTIFICATION

A) I certify the information as provided is true and correct and that the proper evidence for Proof of Age has been submitted;

B) The Participant has received a copy of the ***Special Tax Notice*** regarding plan distributions; and
C) The Application for Disability Retirement Pension has been submitted to the Retirement Committee (governing body).

APPROVAL BY EMPLOYER FOR PENSION BENEFITS

Based on review and action by the Retirement Committee, the Participant named herein has been APPROVED for a Disability Retirement Pension under the terms of the Plan.

_____ _____

Date **Authorized Agent for the Retirement Committee**

PARTICIPANT IS DENIED DISABILITY PENSION BENEFITS

Based on review and action by the Retirement Committee, the Participant named herein does not qualify for a Disability Retirement Pension under the terms of the Plan and the Application for Disability Retirement Pension is DENIED.

_____ _____

Date **Authorized Agent for the Retirement Committee**

Page intentionally left blank for two-sided printing.

Participant to complete

SECTION 5. AUTHORIZATION FOR ACCESS BY PATIENT

NAME: _____ **SSN:** _____ **DATE OF BIRTH:** _____

I hereby authorize the use or disclosure of the Protected Health Information (PHI) described below to be provided to or obtained by the following:

NAME & ADDRESS OF EMPLOYER TO RECEIVE PROTECTED HEATHCARE INFORMATION:

EMPLOYER NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

NAME & ADDRESS OF INDIVIDUAL/FACILITY/COMPANY TO DISCLOSE PROTECTED HEATHCARE INFORMATION:

NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

Information authorized for use or disclosure, or to be obtained: All medical information concerning this patient

The information will be obtained, used, or disclosed for the following purpose(s): Disability Determination.

I UNDERSTAND:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature or upon occurrence of the following event:

  _____

- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the PHI covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

_____ _____

Date **Signature of Patient or Legal Representative**

_____

Description of Legal Representative's Authority

NOTICE OF RIGHTS: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstance including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court of Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Heath or by law.

Employer to complete

SECTION 6. MUNICIPALITY'S CERTIFICATE OF DISABILITY

NAME OF PLAN: _____

NAME OF EMPLOYEE: _____ SOCIAL SECURITY NO: _____

DATE OF DISABILITY: _____ LAST DAY WORKED: _____

What were the duties of the position occupied by the Employee when he/she was first disabled?

_____

_____

_____

To what conditions do you attribute the Employee's disability?

_____

_____

_____

Did these conditions exist on the date the Employee was first employed? ☐ YES ☐ NO

Has the Employee, to your knowledge, previously been disabled so as to acquire medical attention?

☐ Yes ☐ No If yes, when and for what condition? _____

Is the Employee's disability such as to prevent the employee from performing the duties of his/her, or any other, assigned position in your municipality? ☐ YES ☐ NO

Will the Employee be returned to active duty if and when disability ceases? ☐ YES ☐ NO

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT THE ABOVED NAME EMPLOYEE

(a) Has not been separated from the service of this Municipality;
(b) Was in good health upon the first date of participation in the plan; and
(c) Is not entitled to any earnings, other than as stated, from this municipality.

I WARRANT THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT AND NO MATERIAL FACT HAS BEEN CONCEALED OR OMITTED.

_____ _____ _____
Date Signature of Department Head Title

I CERTIFY THAT THIS REPORT IS EXECUTED BY AN AUTHORIZED OFFICIAL OF THIS MUNICIPALITY WHO HAS COMPLETE KNOWLEDGE OF THE FACTS STATED.

_____ _____
Date Authorized Agent for the Retirement Committee

Physician to complete

SECTION 7. PHYSICIAN'S CERTIFICATE OF DISABLITY

This is to certify that I have examined the following named claimant and my report covering the nature and extent of his/her disability is as follows:

NAME OF CLAIMANT: _____ **AGE:** _____ **GENDER:** _____

ADDRESS: _____
(Number and Street) (City, State and Zip Code)

DIAGNOSIS (explain in detail): _____

_____

On what date did illness begin, or injury occur? _____

When did you first treat the claimant? _____ **Where?** _____

How long prior to your first examination did the illness/injury occur? _____

To what do you attribute origin of illness/injury? _____ **Is it chronic?** ☐ **YES** ☐ **NO**

Is this illness/injury a primary condition or is it secondary to, complicated with, or a sequence of some other Illness/injury? ☐ **YES** ☐ **NO**

Has the illness/injury necessitated hospitalization? ☐ **YES** ☐ **NO** **From** _____ **To** _____

Has illness/injury necessitated confinement within the house? ☐ **YES** ☐ **NO**

Was the illness/injury of such severity as to disable claimant for the duties of his/her position? ☐ **YES** ☐ **NO**

Does the illness or injury now prevent any gainful employment by the claimant? ☐ **YES** ☐ **NO**

If no, what limitations exist with respect to the type of work he/she can do? _____

_____

How long will the claimant be unable to be gainfully employed? _____

In your opinion, is this individual totally and permanently disabled so as to be prevented thereby, now and throughout the remainder of his/her life, from engaging in any occupation or employment for remuneration or profits? ☐ **Y** ☐ **N**

I, a practicing physician, duly registered as such under the laws of the sate of _____ **, do hereby Certify that my answers to the foregoing questions are true and complete to the best of my knowledge and belief.**

_____ _____
Date **Signature of Physician**

_____ _____
Phone Number **Print Name**

Address: _____
(Number and Street) (City, State and Zip Code)

State of: _____ **County of:** _____

The forgoing document was signed and sworn to (or affirmed) before me by _____

On this _____ **Day of** _____ **, 20** _____ **Witness my hand and official seal.**

_____ **My commission expires:** _____
Signature of Notary Public