# CITY PENSION FUND FOR FIREFIGHTERS AND POLICE OFFICERS IN THE CITY OF MIAMI BEACH

# APPLICATION FOR DISABILITY BENEFITS

**December 2020**

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**CITY PENSION FUND FOR FIREFIGHTERS AND POLICE OFFICERS IN THE CITY OF MIAMI BEACH**

**APPLICATION FOR DISABILITY BENEFITS**

**EACH QUESTION MUST BE ANSWERED FULLY AND HONESTLY. PLEASE READ CAREFULLY. PLEASE ATTACH ADDITIONAL PAGES IF MORE SPACE IS NEEDED. WHEN ATTACHING ADDITIONAL PAGES, REMEMBER TO INDICATE THE NUMBER(S) TO WHICH THE INFORMATION APPLIES.**

**PLEASE PRINT OR TYPE**

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

b. Social Security Number: _____
*In accordance with the provisions of §119.071(5)(a)6g, Florida Statutes, the collection and use of social security numbers is authorized for the purpose of the administration of the pension Fund.

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

d. Home Telephone/Cell Phone Number: _____
(Area Code) Number

e. Home Address: _____
Address Street

_____
City State Zip Code

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

_____
Street Address

_____
City State Zip Code

_____Please Initial

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: _____
*In accordance with the provisions of §119.071(5)(a)6g, Florida Statutes, the collection and use of social security numbers is authorized for the purpose of the administration of the pension Fund.

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

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

3. a. Date of Hire by the City of Miami Beach: _____
Month-Day-Year

b. Current Position:_____

c. Status of Employment:_____

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

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

_____ Line-of-Duty Disability

_____ Non-Line-of-Duty Disability

_____Please Initial

6. Disability questions:

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 City of Miami Beach terminated? | _____ | _____ |
| (5) | While working for anyone other than the City of Miami Beach and arising out of such employment? | _____ | _____ |
| (6) | A copy of my doctor's medical opinion is attached. | _____ | _____ |

_____Please Initial

**YOU ARE REQUIRED TO SUPPLEMENT THIS QUESTIONNAIRE IMMEDIATELY IN WRITING TO THE BOARD ATTORNEY 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 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

## 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 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 City Pension Fund for Firefighters and Police Officers in the City of Miami Beach 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 Pension Fund.

I hereby agree to indemnify and hold harmless the City of Miami Beach and the Pension Fund and against any and all claims, demands, or causes of action of any kind or nature resulting from or in connection with the City of Miami Beach's release of the results of the undersigned's annual physical to the Pension Fund 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, by means of [ ] physical presence or [ ] online notarization, this____day of_____, 20____, by _____ _____.

_____
Notary Public
Print, type or stamp name of Notary:

_____Personally known or
_____Produced identification

Type of identification produced: _____

# CITY PENSION FUND FOR THE FIREFIGHTERS AND POLICE OFFICERS OF THE CITY OF MIAMI BEACH

## INTERROGATORIES FOR DISABILITY BENEFITS

**PLEASE PRINT OR TYPE**

Name of Employee: _____
(Last) (First) (MI)

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

Home Telephone/Cell Phone Number: _____
(Area Code) Number

Home Address: _____
Number Street

_____
City/Town State Zip Code

PLEASE ANSWER ALL QUESTIONS UNDER OATH:

1. What is the title of your position or your job description?

2. Please describe exactly how you were injured/contracted illness, providing specifics as to date, time and place:

   a. Provide names and addresses of all witnesses.

b. Nature of your injury/illness.

c. Was injury/illness reported to the City of Miami Beach Fire Department or Police Department and if so, state date reported and to whom:

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

| | | | |
|---|---|---|---|
| a. | Total and Permanent | [ ] Yes | [ ] No |
| b. | Service Related | [ ] Yes | [ ] No |
| c. | Non-Service Related | [ ] Yes | [ ] No |

4. 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. For each condition, provide the following(attach a separate sheet if necessary):

a. Specifically when you had the condition.

b. Names, addresses and phone numbers of all health care providers with whom you have consulted or who treated you.

c. The diagnosis.

d. The prognosis.

e. Dates of treatment.

f. Nature of treatment.

g. Medications prescribed.

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

5. Please provide the names, addresses and telephone numbers of all health care providers who have treated you for the condition upon which your claim is based and any condition related to it. Please provide the following:

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

b. The diagnosis.

c. The prognosis.

d. Dates of treatment.

e. Nature of treatment.

f. Medications prescribed.

g. Names, addresses and telephone numbers of all persons who may have knowledge of such condition.

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

a. When accident occurred.

b. Where and when accident occurred.

c. How accident occurred.

d. Whether you were injured.

e. How you were injured.

f. Was accident job related.

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

(1) Diagnosis.

(2) Prognosis.

(3) Medications prescribed.

(4) Nature of treatment.

(5) Dates of treatment.

(6) Names, addresses and telephone numbers of all persons who may have knowledge of injuries resulting from the accident.

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

a. A description of the incident.

b. Where and when it occurred.

c. How it occurred.

d. Whether you were injured.

e. How you were injured.

f. Was it job related.

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

(1) Diagnosis.

(2) Prognosis.

(3) Medications prescribed.

(4) Nature of treatment.

(5) Dates of treatment

(6) Names, addresses and telephone numbers of all persons who may have knowledge of injuries resulting from the accident.

8. Please provide names, addresses and dates of all prior and current employers, including self-employment.

a. Nature of work involved with employment.

b. Status of each employment (terminated, retired, continuing, etc).

c. Basis or reason for any termination of employment.

9. Were you suffering any injury/illness, disease, or disability at the time of the accident, incident or condition for which you are applying for disability retirement?

10. Describe all records of the accident or incident forming the basis of your application, including, traffic accident reports, police reports, notice of injury/illness, hospital records etc.

11. 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 as a Firefighter or a Police Officer as a result of the condition or injury/illness which is the basis of your claim for disability retirement.

12. Provide the name and address of all health care providers who have advised you that you are **not** permanently and totally incapable of performing useful and efficient service as a Firefighter or a Police Officer as a result of the condition or injury/illness which is the basis of your claim for disability retirement.

13. 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 MMI.

14. Provide the names and addresses of all health care providers who have advised that you have **not** reached MMI.

15. Has your sworn statement or testimony been taken in connection with any claim arising out of the injury/illness or condition which is the basis for your claim for disability. If so, state the date taken and by whom.

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

17. Have you ever applied for workers' 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.

18. Describe in detail why you feel that you are permanently and totally unable physically or mentally from performing useful and efficient service as a Firefighter or Police Officer.

## 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 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 hereby agree to indemnify and hold harmless the City Pension Fund for Firefighters and Police Officers in the City of Miami Beach from and against any and all claims, demands, or causes of action of any kind or nature resulting from or in connection with the Board's use of my medical records to process my application, and from and against any resulting losses, costs, expenses, reasonable attorneys' fees, liabilities, damages, orders, judgments, or decrees in connection therewith.

I understand that I have a continuing duty to immediately supplement this questionnaire in writing with any new or additional information obtained.

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 by means of [ ] physical presence or [ ] online notarization, this_____day of_____, 20___, by_____*(Participant)* who is: [ ] Personally known to me - ***OR*** - who [ ] produced the following identification:

_____
Specify type of identification produced

_____ _____
**Signature of Notary** ***Print, type or stamp name of Notary in addition to seal***

Name: _____

## AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Demographic Data

Patient Name_____ Clinic Record #_____

Patient Address: _____ Date of Birth: _____

**INFORMATION TO BE RELEASED BY: Name:**_____
**(This may include Medical Records, Billing or Other Departments)**

**(Department and Address): All medical records; entire file**

**PURPOSE OF DISCLOSURE** (must complete): At the Request of the Individual ☐ Continuity of Care
☐ Other (describe)_____

**SPECIFIC INFORMATION TO BE RELEASED:**_____ **-ENTIRE FILE**_____

**SEND INFORMATION TO:** (please be specific)

Provider/Name/Organization: Stuart A. Kaufman, Klausner Kaufman Jensen & Levinson

Address: 7080 N.W. 4th Street Plantation. Florida 33317

Phone#: (954)916-1202 Fax#: (954) 916-1232

This form must be received within 6 months of the date that it is signed, and it is valid for 90 days after receipt. It may be revoked at any time upon my written request to Donna Brito unless the requested information has already been disclosed. A fax machine may be used to transmit information, and faxing may increase the risk of accidental disclosure of this information to unauthorized parties. Information released may include but is not limited to alcohol or drug abuse, HIV, mental health, or communicable disease information, which may be part of your health record. Your medical history may contain records from other health care providers. Please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA Rules. If I refuse to sign this authorization, my information will not be released except as required by law. We will not condition treatment on the completion of the authorization.

***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§§175.195 and 185.185.**

Signature:_____ Date:_____

Print Name:_____

If signed by Representative, Description of Relationship to Patient and Authority:_____