Application Packet Cover Sheet

Fire & Police Pension Association of Colorado

7979 East Tufts Avenue, Suite 900 | Denver, Colorado 80237
Phone: (303)770-3772 (800) 332-3772 Fax: (303)771-7622 Website: FPPAco.org

For	FPPA Active Members
Who Are Applying For	Disability Retirement
Under The	Statewide Death & Disability Plan

This packet applies to:
Active members who are applying for disability retirement.

Please remember:
- Read the Step by Step booklet carefully prior to completing the application.
- Have your signature notarized where required.
- Submit the necessary documentation.

Questions?
Contact an FPPA Benefit Administrator at the phone numbers listed above.

Send all completed forms to:
FPPA Benefit Administrator at the address listed above.

For your records, please make copies of the forms you fill out prior to submitting them to FPPA.

Forms & Publications	In this application packet you will find the following forms and information needed to process your application. Check the box to the left as you complete each of the forms.	
☐	Instructions Memo	2 pages
☐	Disability Retirement Application Packet 1 - Applicant's Section	6 pages
☐	Disability Retirement Application Packet 2 - Medical Section	6 pages
☐	Disability Retirement Application Packet 3 - Employer's Section	5 pages

Application Packet

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Instructions Memo

This memorandum, together with the Step by Step Through the Disability Process booklet, will explain the steps required to apply for disability benefits. Please read the Step by Step booklet thoroughly as it will explain the disability procedures, process and rules in detail. Please also review Part 8 of the Colorado Revised Statutes and Parts 16 and 17 of the FPPA Rules & Regulations. Both may be found on our web site. To begin the process, you must complete the Disability Retirement Application.

The application consists of three parts: Packets 1, 2 and 3. Packet 1 is to be completed by you. The information requested is general in nature. With Packet 1, please submit any applicable supporting documents (see Supporting Documents list on Part 1-D). Also, please note, your signatures on pages 4, and 6 of Packet 1 must be notarized.

Packet 2 requests medical information. Parts A, B and D are to be completed by you. Part C is to be completed by your physician(s). If you have more than one physician, you may photocopy Packet 2.

Packet 3 must be completed by your employer. A copy of your job description or statement of your assigned duties must be submitted with this packet.

FPPA suggests that when you distribute Packets 2 and 3, you request that your employer and physician(s) return the packets to you. This will allow you to submit the entire application to FPPA when you are ready to start the process. Once any part of the application is received by FPPA, you have only 90 days to submit the remainder of the application. If it is not submitted within the 90-day time period, it will be considered withdrawn.

The disability process itself typically takes 120 days once FPPA receives your completed application. However, it may take longer if there are complications or if an evidentiary hearing is requested. We will do everything possible to keep the process moving quickly and smoothly and we appreciate your patience and cooperation throughout the process.

We realize this may not be an easy process to go through, so please feel free to call if you have questions or concerns at (303) 770-3772 or (800) 332-3772, ext. 6300.

FPPA | **Fire & Police Pension Association of Colorado**
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Disability Retirement Application
Packet 1 - Applicant's Section

Dear Applicant:

This packet and the two others attached are your complete application for FPPA disability retirement. FPPA offers two types of disability retirement:

- **Occupational Disability**, which means a disability resulting in an incapacity to perform assigned duties and expected, with reasonable medical probability, to exist for at least one year.

  Within the Occupational category, there are two sub-categories: Temporary Occupational Disability and Permanent Occupational Disability.

  Temporary Occupational Disability - an occupational disability for which these is prognosis for improvement or recovery through surgical treatment, counseling, medication, therapy, or other means.

  The Temporary Occupational Disability benefit is payable for a maximum of five years. If at that time you have not returned to the police or fire department or your disability status has not changed to a Permanent or Total Disability, your benefit is terminated. Please refer to FPPA Rule 1706 as application deadlines apply.

  Permanent Occupational Disability - an occupational disability caused by a condition that is permanent or degenerative, and for which there is no prognosis for improvement or recovery through surgical treatment, counseling, medication, therapy or other means.

- **Total Disability**, which means an inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that may be expected to result in death or that has lasted or may be expected to last for a period of not less than 12 months.

FPPA disability retirement, including eligibility, benefit levels and options, is explained in the *Step by Step Through the Disability Process* booklet; Part 8, Article 31, Title 31 of the *Colorado Revised Statutes*, as amended; and *FPPA Rules and Regulations*, all of which can be found on the website at FPPAco.org or obtained from FPPA's offices. You are urged to consult these sources for detailed information. The following is simply an explanation of how to file an application.

Instructions

As the applicant for disability retirement, you are responsible for ensuring that this packet and Packets 2 and 3 are completed properly and returned to FPPA. (If, because of medical reasons, you are unable to complete your application, you may execute a power of attorney, appointing someone to act on your behalf. Please contact your attorney to do so, and send a certified copy of the power of attorney to FPPA.)

If you believe you are disabled, you are encouraged to apply for disability retirement before terminating your employment.

FPPA will NOT accept an application more than 365 days after you last day on payroll. Your employer must certify you last day on payroll to FPPA. *Per FPPA Rules & Regulations - Rule 1605.*

Each of the three packets contained in this application carries its own instruction; please read them carefully. In Packet 1; Part 1-C, Part 1-E and in Packet 2;m Part 2-D must be signed in the presence of a notary. When completed, photocopy the entire application for your files and return the original to FPPA.

All three packets, completed, must be received by FPPA before you will be scheduled for medical examinations by its panel of physicians.

As soon as all packets are received, FPPA will process your application as quickly as possible. The determination of disability retirement, however, is a lengthy process taking a minimum of 120 days to complete.

You will receive additional information as your application moves through the disability process. Meanwhile, if you have questions, please contact an FPPA Death & Disability Benefit Coordinator.

IMPORTANT NOTE: If at any time you are not eligible for benefits and FPPA has inadvertently made an overpayment, you will be required to return the overpaid amount to FPPA. If you are granted a temporary occupational disability, FPPA will require treatment, counseling or therapy at your own expense, necessary for you to rehabilitate for return to work and you may periodically reexamined.

Part 1 - A General Applicant Information

Last Name ____ First ____ Initial ____

Mailing Address ____ Apt. # ____

City ____ State ____ Zip Code ____

Social Security Number ___ - ___ - ___

Email Address ____

Home Phone Number ___ - ___ - ___

Cell Phone Number ___ - ___ - ___

Work Phone Number ___ - ___ - ___

Part 1 - B Disability Application

APPLICANT

I, (insert name)________________________ hereby apply for disability retirement under the provisions of Part 8, Article 31, Title 31 of the *Colorado Revised Statues*, as amended. The following information is provided to support my application for disability retirement.

Employer's Name *(name of city, town or special district)* ____ ☐ Police ☐ Fire

Starting Date ___ / ___ / ___

Birth Date ___ / ___ / ___

Base Salary* $ ____ *(gross annual salary)*

Rank ____

Are you Single? ☐ Yes ☐ No

If "no," check which applies: ☐ Married ☐ Common-Law ☐ Civil Union

Have you ever been divorced? ☐ Yes ☐ No

Is any domestic relations order (DRO) attached to your retirement plan? ☐ Yes ☐ No

If "yes," and you are in a money purchase plan, please provide a copy of the statement(s) showing the amount and date of the distribution(s).

Is any (DRO) attached to any FPPA disability retirement? ☐ Yes ☐ No

**See the FPPA Rule regarding definition of base salary for your plan on the FPPA website at FPPAco.org.*

Applicant Background

Have you ever, in this state or any other state, applied for disability benefits? ☐ Yes ☐ No

If "yes," who was your employer? ____________________

If "yes," were you found disabled? ☐ Yes ☐ No

If "yes," were disability benefits awarded? ☐ Yes ☐ No

Are you currently receiving a disability benefit? ☐ Yes ☐ No

Have you ever been assigned a Disability Impairment Rating from a workers' compensation provider?

☐ Yes ☐ No If "yes," please provide a copy of the Final Admission of Liability (all pages).

Please indicate below how many days you have used in the last 12 months due to the condition for which you are claiming disability.

_______ Sick Days Used _______ Vacation Days Used _______ Unpaid Days Taken

_______ Other, please specify ____________________

If you do not have specific records on the number of work days missed in the past 12 months due to this particular condition, please indicate the total number of days used in the last 12 months.

_______ Sick Days Used _______ Vacation Days Used _______ Unpaid Days Taken

_______ Other, please specify ____________________

Are you currently working elsewhere in capacity? ____________________

If within a five-year period from the date of your disability retirement you are found no longer disabled, you may become eligible for reinstatement with your former employer. At this time, you may irrevocably elect not to be considered for reinstatement. Waiving your right to reinstatement shall terminate any obligation for reinstatement by your employer. If you are found no longer disabled and you have waived your right to reinstatement, your disability benefits shall terminate. You are advised to consult an attorney regarding your legal rights.

Do you wish to waive this right to reinstatement? ☐ Yes ☐ No

Are you eligible to receive a retirement benefit from a local Colorado police or fire department? ☐ Yes ☐ No

Name of Department ____________________

Spouse of Applicant

Spouse's Name	Spouse's SS Number	Spouse's Birth Date
	___-___-___	___/___/___

Dependents of Applicant

Please list below the names and birth dates of ALL your unmarried children under age 23. If necessary, attach a separate sheet listing additional children. Please refer to the FPPA Rules and Regulations on the web site at FPPAco.org for the definition of dependent children.

Is the member's household the permanent address of this child?

Child's Name	Social Security Number	Birth Date (month, day, year)	Yes	No
	___-___-___	___/___/___	☐	☐
	___-___-___	___/___/___	☐	☐

Please list below the names and birth dates of any of your children of any age or marital status who are so mentally or physically incapacitated that they cannot provide for themselves.

Child's Name	Social Security Number	Birth Date (month, day, year)
	___-___-___	___/___/___
	___-___-___	___/___/___

Part 1 - C Designated Beneficiary

My designated beneficiary is: (**Note:** Only one person can be named as your beneficiary.)

Beneficiary's Full Legal Name ☐ Female ☐ Male Beneficiary's SS Number ___-___-___

___/___/___ Relationship of beneficiary to applicant: ___

Beneficiary's Birth Date (month, day, year)

If spouse, check which applies: ☐ Married ☐ Common-Law ☐ Civil Union

___-___-___

Beneficiary's Phone Number Beneficiary's Email Address

Beneficiary's Mailing Address Apt. #

City State Zip Code

Note: If your beneficiary does not reside with you, it is your responsibility to notify FPPA in the event your beneficiary changes his or her address.

Required Signature

Applicant's signature is required below.

I certify that the information stated herein is correct to the best of my knowledge.

Please sign and date below:

Applicant's Full Legal Signature Date ___/___/___

Required Notarization

Applicant's signature is required to be notarized below.

STATE OF ___ } ss

COUNTY OF ___

Subscribed and sworn to before me this ___ day of ___, year of ___.

Witness my hand and official seal.

My commission expires: ___/___/___.

Notary Public Signature

SEAL

Part 1 - D Supporting Documents

To support your application, certain legal documents are required by FPPA. Please compile all the supporting documents listed below which are applicable to you. Legible photocopies are acceptable.

Return your supporting documents to FPPA with your application. Please check the applicable documents below.

If you have questions on which supporting documents you should supply to FPPA, please contact an FPPA Death & Disability Coordinator at the address or telephone number listed on the front of this application.

- ☐ Your birth certificate and driver's license

  If married, civil union or common-law:

  - ☐ Marriage - Marriage Certificate
  - ☐ Civil Union - Civil Union Certificate
  - ☐ Common-Law - Documentation proving this relationship

    Note: Such proof may include, but shall not be limited to: evidence that you claimed married status for tax purposes, evidence of common-law coverage for insurance, and/or evidence that you presented yourself as married).

- ☐ Your spouse's birth certificate and driver's license.
- ☐ Your beneficiary's birth certificate and driver's license (if your beneficiary is someone other than your spouse).
- ☐ The birth certificate(s) of your unmarried children under age 23, including natural children, adopted children, step-children, and unrelated children living in your household if you have the right to claim the children as dependents for federal income tax purposes.
- ☐ A physician's statement certifying that a child has been conceived but not yet born.

  Note: After birth, send FPPA a copy of the child's birth certificate.

- ☐ A physician's statement certifying that a child(ren) is so physically or mentally incapacitated that he/she cannot provide for him/herself. And, if such child is over the age of 23, the birth certificate of the child(ren).
- ☐ If you participate in a money purchase plan, provide a copy of an account statement as of your last day on the employer's payroll and a copy of the statement(s) showing the date(s) and amount(s) of any distribution(s). If the last day on payroll is a future date, attach a current account balance statement, with final statement submitted after your last day on payroll.
- ☐ If applicable, provide documentation supporting your claim for an on-duty disability determination (as discussed in Packet 2, page 3).
- ☐ If you have been divorced, provide a copy of any Domestic Relations Order(s).

Reminder: Please submit supporting documents to FPPA along with the completed application.

Part 1 - E FPPA Records and Medical Information Release

Dear Applicant,

It is FPPA's policy on confidentiality of information not to release any information contained in your FPPA file without your consent. If you wish to have such information released to someone other than yourself, please complete this *Records and Medical Information Release* form indicating what type of information may be released and to whom FPPA may release it. Otherwise, insert your own name. This release must be completed and signed in the presence of a notary public.

FPPA RECORDS RELEASE

I, the undersigned member of the Fire and Police Pension Association, hereby authorize FPPA to release the following information contained in my membership file:

TYPE OF INFORMATION ______________________________

RELEASE TO the following person(s) requesting information:

____

____

I, (insert name, ______________________________ have applied to FPPA for disability retirement. I hereby authorize any medical doctor or specialist who has examined or treated me to release and transmit to FPPA all my medical, substance abuse or mental health records, including but not limited to, narrative reports, statements of opinion, office charts, x-rays, correspondence or reports from my employer or other test data and results. I further authorize said doctor or specialist to confer with the FPPA Medical Advisor.

I further authorize any hospital, infirmary, clinic or other institution of a similar nature to which I have been admitted,either on an in-patient or out-patient basis, to release and transmit to FPPA all of my medical records and other pertinent information.

______________________________ ______ /______ /______

*Applicant's Full Legal Signature** *Date*

Note: This authorization expires six months from date signed or until revoked, if earlier.

Required Notarization

Applicant's signature is required to be notarized below.

STATE OF ______________________ }
COUNTY OF ____________________ } ss

Subscribed and sworn to before me this __________ day of ______________, year of __________ .

Witness my hand and official seal.

My commission expires: ______ /______ /______ .

____

Notary Public Signature

SEAL

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Disability Retirement Application
Packet 2 - Medical Section

INSTRUCTIONS

To the applicant:

Please complete Part 2-A and Part 2-B. You must also complete and sign Part 2-D in the presence of a notary public.

Retain a copy of this packet for your files and forward the original to your personal physician. (If you are being treated by more than one physician, please photocopy this packet and submit one copy to each physician. See special instructions on the medical release contained herein.)

To the applicant's physician:

The applicant named in Part 2-A below has applied to FPPA for disability retirement. Because you are the applicant's personal physician, FPPA requires your statement regarding the applicant's medical condition.

After reviewing FPPA's definitions of disability and the applicant's statement concerning his/her condition on Part 2-B of this packet, please give your statement on Part 2-C. **If applicable, please also provide a treatment plan, including treatment, counseling or therapy necessary to rehabilitate the applicant for return to work.** (Additional information is provided on page 4.)

The enclosed Medical Information Release (Part 2-D) is for your files and for possible future use if FPPA requires further information. At your earliest convenience, please return to the applicant Packet 2, medical records relevant to the claimed condition, and treatment plan, if applicable.

Each applicant for FPPA disability status may be examined by a panel of up to three physicians appointed by FPPA. Your detailed diagnosis will be helpful in determining which type of FPPA physicians will examine the applicant.

Your cooperation in this matter is greatly appreciated.

Part 2 - A General Applicant Information

Last Name	First	Initial
Mailing Address		Apt. #
City	State	Zip Code

Part 2 - B Applicant's Statement of Disability

To be completed by the Applicant:

1. Please list ALL physician(s) who have examined or treated you for the condition(s) for which you are now claiming disability. You must submit a Physician's Statement of Disability (see Pages 4-5) for each doctor listed who has treated you for the claimed condition.

Please submit supporting medical documentation for each condition listed.

2. Please state specifically:
   1.) the nature of the disability which you claim affects your ability to perform your job;
   2.) the circumstances surrounding the onset of your injury of illness;
   3.) when the injury occurred or when the condition was diagnosed;
   4.) the date on which your condition began to affect your ability to perform you job; and
   5.) those specific tasks or duties assigned to you by your employer which you are now unable to perform.

(You may use a separate sheet if more convenient, but please refer to which question you are answering.)

3. If you have had any of the following diagnostic tests in the past two years, please check all that apply. Be sure to include reports on these diagnostic tests with your application and take the films or CD's to all of the appointments with the FPPA examining physicians.

☐ X-ray ☐ MRI ☐ Radiologic scan ☐ CT scan ☐ Ultra Sound ☐ EKG

4. To your knowledge, was the claimed disabling condition caused by:

- addiction to a controlled substance? ☐ Yes ☐ No
- engaging in any act for which you have been convicted of a felony ☐ Yes ☐ No
- an intentionally self-inflicted injury? ☐ Yes ☐ No

5. Do you contend that your disability is the result of an injury received while performing official duties for your employer or an occupational disease arising out of or in the course of your employment with your employer?

☐ Yes ☐ No

If "yes," please set forth the basis of your claim, including, if applicable, the date(s), time(s) and place(s) of your injury(ies).

____

____

What supporting documentation for your on-duty claim is included with this application?

☐ Records establishing that the injury or occupational disease was compensable under the Workers' Compensation Act of Colorado as having occurred in the course of employment. (See C.R.S. 8-40-201 (17).) Including but not limited to copies of any Admissions of Liability that you have received.

☐ Employer records as of the date of the injury that support the proposition that the disability resulted from an injury received while performing official duties or an occupational disease arising out of and in the course of your employment.

☐ Other records or documents that support the proposition that the disability resulted from an injury received while performing official duties or an occupational disease arising out of and in the course of your employment.

Please list document below.

____

____

6. Please describe, in your own words, your assigned duties: *(Please do not write "see job description.")*

____

____

____

Required Signature

Applicant's signature is required below.

____ ______ /______ /______

Applicant's Full Legal Signature Date

To the Physician:
The Fire and Police Pension Association offers two types of disability retirement:

- **Occupational Disability**, which means a disability resulting in an incapacity to perform assigned duties and expected, with reasonable medical probability, to exist for at least one year.

  Within the Occupational category, there are two sub-categories: Temporary Occupational Disability and Permanent Occupational Disability.

  Temporary Occupational Disability - an occupational disability for which these is prognosis for improvement or recovery through surgical treatment, counseling, medication, therapy, or other means.

  Permanent Occupational Disability - an occupational disability caused by a condition that is permanent or degenerative, and for which there is no prognosis for improvement or recovery through surgical treatment, counseling, medication, therapy or other means.

- **Total Disability**, which means an inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that may be expected to result in death or that has lasted or may be expected to last for a period of not less than 12 months.

On Part 2-C below, give a detailed diagnosis, treatment plan (if applicable), and statement for the applicant identified. Please include dates of hospitalization. A signed and dated medical history, listing diagnosis, documented by laboratory results and/or x-rays or other test results, may be attached to this packet in lieu of medical reports.

Physicians, please note that medical information provided by you in Part 2-C of this packet will be released by FPPA to the applicant identified in Part 2-A, and to third parties, if so requested by that applicant.

Part 2 - C Physician's Statement of Disability

Name of Applicant ______________________________

I, (insert your name) ______________________________,

hereby certify that I am physician duly licensed to practice medicine in the State of ______________

I further certify that I have:

Check one: ☐ Professionally attended the above-name applicant from

_____/_____/_____ (Month, Day, Year) to _____/_____/_____ (Month, Day, Year); or

☐ Examined the above-named applicant on _____/_____/_____ (Month, Day, Year)

I further certify that I have found the injuries, infirmities, diseases or disabilities of the above named applicant to be as follows (Please type or print legibly):

Diagnosis: ______________________________

Recommended Treatment Plan, including treatment, counseling, or therapy necessary to rehabilitate the applicant for return to work:

____

If additional space is needed, please attach a separate sheet. ☐ Check here if an additional sheet is attached.

Based on the disability definitions given on page 4, the applicant identified in Part 2-A, in your opinion, meets the definition of:

Check one:
- ☐ Temporary Occupational Disability
- ☐ Permanent Occupational Disability
- ☐ Total Disability
- ☐ Not Disabled

Can it now be determined when the applicant identified in Part 2-A will be able to resume his/her assigned job duties as defined in the official job description provided by the employer? ☐ Yes ☐ No

If yes, when will the applicant be able to resume his/her assigned job duties?

____

Physician's Signature ____________ Date ____ / ____ / ____

Mailing Address ______________________________

City ____________ State ____________ Zip Code ____________

Phone Number ____ - ____ - ____ Name of Applicant ____________

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Part 2 - D Medical Information Release

To the Physician:
This medical release is for your files and applies only to the application for disability retirement by the below- named police officer or firefighter. Please do not forward information about the applicant to FPPA unless specifically requested to do so in the future. If you have questions, please contact an FPPA Death & Disability Benefit Coordinator at the address or phone number listed above.

To the Applicant:
Please make a copy for each of your doctors for whom you submit a report and leave a copy with each doctor. The original copy with original notary information should be submitted to FPPA with your disability application.

To be completed by the applicant and signed in the presence of a notary public:

I, (insert your name) ______________________________, have applied to FPPA for disability retirement. Upon specific future request, I hereby authorize any medical doctor or specialist who has examined or treated me to release and transmit to FPPA specified medical, substance abuse or mental health records, including, but not limited to, narrative reports, statements of opinion, office charts, x-rays, and other test data and results. I further authorize said doctor or specialist to confer with the FPPA Medical Advisor.

I further authorize any hospital, infirmary, clinic or other institution of a similar nature to which I have been admitted, either on an in-patient or out-patient basis, upon specific future request, to release and transmit to FPPA specified medical records and other pertinent information.

I further authorize FPPA to release to me, upon my request, a copy of any and all medical records submitted by my personal physician to FPPA in Packet 2 of the official disability retirement application.
I further authorize FPPA to release my application, medical records, and any other pertinent information to an institution for purposes of vocational assessment.

I understand that FPPA will retain, but protect the confidentiality of, such records and information but that its Board of Directors, employees, agents and panel of physicians must examine such records and information to evaluate my application for disability retirement.

Applicant's Full Legal Signature ______________________________ Date ______________

Required Notarization

STATE OF ______________________ }
COUNTY OF ____________________ } ss

Subscribed and sworn to before me this __________ day of ______________, year of __________ .

Witness my hand and official seal.

My commission expires: ________ / ________ / ________ .

____
Notary Public Signature

SEAL

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Disability Retirement Application

Packet 3 - Employer's Section

INSTRUCTIONS

To the Applicant:

Please complete Part 3-A; then give this packet to your employer for completion of Parts 3-B through 3-E. To avoid missing the application completion deadline, FPPA suggests that you ask your department to return this packet to you. Then you should submit your entire application to FPPA. It is suggested that you retain a photocopy for your files.

To the Employer:

The applicant identified in Part 3-A below has applied to FPPA for disability retirement. FPPA requires you, as the applicant's employer, to certify certain items, such as the applicant's salary.

Please complete Parts 3-B through 3-E. Additional instructions are provided in each part. If you have questions or require additional information, please contact an FPPA Death & Disability Benefit Coordinator.

A hearing on this application cannot be scheduled until this packet has been completed and returned to FPPA. Either you or the applicant may submit the completed packet to FPPA, but it is suggested that you retain a photocopy for your files.

Your cooperation is greatly appreciated.

Part 3 - A General Applicant Information

______________________ ______________________ __________
Last Name First Initial

____ __________
Mailing Address Apt. #

______________________ ______________________ __________
City State Zip Code

_______-_______-_______
Social Security Number

Part 3 - B Employer's Statement of Applicant's Disability

1. Please indicate the applicant's current employment/payroll status. ☐ Special Injury ☐ Terminated

☐ Disability ☐ Light or Modified Duty ☐ Full Duty ☐ Worker's Compensation ☐ Sick/Vacation Pay

a. If applicable, please give the date on which this applicant was placed on special injury, disability, light or modified duty, Workers' Compensation or sick/vacation pay status: ________ /________ /__________

2. Is this applicant receiving any type of special compensation while on special injury or disability status? ☐ Yes ☐ No

a. If "yes," list the type(s) of compensation being paid to the applicant, including sick leave and other types of compensation. Do not include vacation pay.

3. Is the applicant receiving full pay? ☐ Yes ☐ No

4. Was this injury/illness document with the department? ☐ Yes ☐ No

5. Please indicate below how many days the applicant has used in the last 12 months due to the condition for which he/she is claiming disability.

__________ Sick Days Used __________ Vacation Days Used __________ Unpaid Days Taken

a. If you do not have specific records on the number of work days missed in the past 12 months due to this particular condition, please indicate the total number of days the applicant has used in the last 12 months.

__________ Sick Days Used __________ Vacation Days Used __________ Unpaid Days Taken

6. Was a Workers' Compensation claim filed in relation to this injury? ☐ Yes ☐ No

7. Who is your Workers' Compensation carrier (i.e. self-insured or separate carrier)? ☐ Yes ☐ No

Carrier	Phone Number
Mailing Address	Claim Number

City	State	Zip Code

8. Has Workers' Compensation accepted liability? ☐ Yes ☐ No ☐ Pending ☐ N/A

9. Was a Statewide Standard Health History Form filed on this applicant with FPPA? (This was required for member hired on or after 9/1/89.) ☐ Yes ☐ No

10. To your knowledge, was the condition caused by:

- addiction to a controlled substance? ☐ Yes ☐ No
- engaging in any act for which you have been convicted of a felony ☐ Yes ☐ No
- an intentionally self-inflicted injury? ☐ Yes ☐ No

11. Was the member's condition the result of an injury received while performing official duties or an occupational disease arising out of and in the course of the member's employment? ☐ Yes ☐ No

The Criteria

In making its decision whether a disability was the result of an injury received while performing official duties or an occupational disease arising in the course of the member's employment, FPPA will consider the following standards:

An "injury received while performing official duties" means an injury occurring:

1.) during a scheduled shift of the member; or
2.) while the member is otherwise performing official duties for the employer; or
3.) while the member is performing official duties in the employ of a third party and the employment is authorized by the member's employer.

A member's official duties are those set forth in the written job description for the member's position. The term does not include the duties of a member's rank or grade that the member is not actually required to regularly perform.

An "occupational disease" will be determined to have resulted directly from the employment of the member, or the conditions under which work was performed, if it follows as a natural incident of the work and as a result of the exposure occasioned by the nature of the employment as a proximate cause and does not come from a hazard to which the member would have been equally exposed outside of the member's employment.

12. Does the employer believe there is an additional basis/condition to be assessed for disability? ☐ Yes ☐ No

If "yes," please specifically state the condition.

If you have answered Yes to the above question, the employer is required to include relevant evidence with this application. If the applicant's disability ceases to exist and he/she becomes eligible for reinstatement, he/she may be required to be examined for a continuing disability based on the employer's statement of additional basis for disability. If the applicant refuses to be examined on the additional basis for disability, he/she will be ineligible for reinstatement and benefits will be terminated.

13. ________ /________ /__________ ______________________________________

Applicant's Date of Hire Current rank held or final rank held if terminated.

14. What coverage does the applicant have for normal retirement?

☐ Statewide Defined Benefit Plan
☐ Local defined benefit plan ☐ Statewide Money Purchase Plan ☐ Statewide Hybrid Plan
☐ Local money purchase plan ☐ Colorado Springs New Hire Plan ☐ Other: ____________________

Please indicate.

15. If the applicant was hired after January 1, 1997 please answer the following:

Who is paying the Death & Disability Contribution?

Employee _______ % ☐ Pre-tax ☐ Post-tax Employer _______ %

16. If the applicant is a member of your **local defined benefit plan**, what are the age and service requirements for normal retirement under that plan?

Years of service requirement __________ Age requirement (if none, please use N/A) __________________

17. If the applicant is a member of a **money purchase plan**, is he/she considered 100% vested upon approval of a long-term disability benefit? ☐ Yes ☐ No

If "no," what is the member's vested percentage in each account? Employer ________% Employee _______ %

Please list the contribution level: Employer ________% Employee ________%

a. If you maintain a **local money purchase pension plan**, please attach a copy of the applicant's latest account statement and provide the mandatory contribution rates. If applicant has terminated employment, attach an account statement as of the applicants last day payroll.

18. Has the member taken a distribution fro his/her **money purchase plan**? ☐ Yes ☐ No

a. If "yes," please provide a copy of the statements showing the distributions.

b. If "yes," was any part of the distributions made pursuant to a Domestic Relations Order (DRO)? ☐ Yes ☐ No

Part 3 - C Payroll Date & Salary Certification

FPPA will NOT accept an application for disability retirement more than 365 days after the applicant's last day on the payroll. Per FPPA Rules & Regulations - Rule 1605.04.

The last day on the payroll for the purpose of filing the application may or not include any or all accrued leave or vacation.

Last day on job & payroll - *FPPA uses these dates to determine benefit commencement date.*

1. The applicant's last day worked (full duty, light duty or modified duty). Check one of the following:

☐ Date is pending FPPA determination ☐ Specific date (please list) ________ /________ /__________

2. The applicant's **last day on the payroll**, i.e. the last day the member was credited with earnings. This includes, but is not limited to, pay for full duty, light or modified duty; or pay for accumulated leave that is being exhausted (not paid in a lump sum); or pay due to donated time for co-workers. Check one of the following:

☐ Date is pending FPPA determination ☐ Specific date (please list) ________ /________ /__________

If you mark "Date is pending FPPA determination," FPPA will notify the Member and Employer of the effective date of any award of benefits.

3. If the applicant has already terminated employment, state the reason for termination and attach a copy of the termination letter or other documentation of the reason for termination. ______________________________

____

4. Enter the applicant's annual base salary, including longevity pay or shift differential pay, if applicable. $______
See the FPPA Rule regarding definition of base salary for your plan on the FPPA website at FPPAco.org.

Part 3 - D Assigned Duties

Please attach to this Packet 3 a statement of assigned duties for the applicant identified in Part 3-A of this packet. The statement of assigned duties should pertain to the applicant's current position (or final full-duty position, if terminated).

Assigned duties means those specific tasks or jobs designated by the employer for a particular position within a job classification. The term does not include the duties of a member's rank or grade which the member is not actually required to regularly perform in the position which the member occupies.

- Please do not send applicant's official description for his/her rank or grade unless the applicant is currently required to regularly perform all duties outlined in the job description.
- Also, do not send a job description for temporary, light or modified duty assignments.

Is the applicant required to regularly perform all of the job duties stated on the enclosed job description?

☐ Yes ☐ No

1. Pursuant to Section 31-31-803(4)(c), Colorado Revised Statutes, if the Board determines that an applicant for retirement for disability is not disabled, and the applicant is on sick leave, disability leave, or other type of leave of absence, is serving in a temporary position pending the determination of an application, or has been terminated from employment by the employer on the basis of an alleged disability, the employer shall reinstate the applicant to active service in the same position or a position of equal base pay the applicant held prior to commencement of such leave, assignment to a temporary or modified position, or termination.

If the employer refuses to reinstate the applicant to his prior position, the employer shall thereafter pay benefits to the applicant as if the applicant had been determined occupationally disabled by the Board. The employer shall continue to pay such benefits until the applicant is reinstated to the applicant's prior position or declines an offer of reinstatement.

Part 3 - E Employer's Responsibility for Reinstatement

Signature of Authorized Personnel ____________________ Title ____________________

Print Name ____________________ City/Town or F.P.D. ____________________

Mailing Address ____________________ City, State, Zip Code ____________________

Phone Number ____________________ Email ____________________

_______ /_______ /_______
Date