FPPA 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	**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 all required 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 or call FPPA to receive a link to upload documentation through our secure upload system. *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.**	
☐	Before You Apply 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

FPPA Application Packet

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Before You Apply

This memo, together with the Step by Step Through the Disability Process booklet, explains 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 the *Colorado Revised Statutes* and the FPPA *Rules & Regulations* that govern this plan. Both can be found at FPPAco.org.

The application consists of three parts. 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 the *Supporting Documents* list on Part 1-D). Please note that your signatures on pages 4 and 6 of Packet 1 must be notarized.

Packet 2 requests medical information. You will complete Parts A, B, and D, and your treatment provider(s) will complete Part C. If you have more than one provider, you may copy 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 provider(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 navigate, so please call FPPA if you have questions or concerns at (303) 770-3772 or (800) 332-3772, ext. 6300.

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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 there 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 your police or fire department or your disability status has not changed to a Permanent Occupational Disability 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 payment options, is explained in the *Step by Step Through the Disability Process* booklet; the *Colorado Revised Statutes*, as amended; and *FPPA Rules & Regulations*, all of which can be found at FPPAco.org or obtained at FPPA's offices. Please consult these sources for detailed information.

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 you are unable to complete your application for medical reasons, 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, FPPA encourages you to apply for disability retirement before terminating your employment.

FPPA will NOT accept an application more than 365 days after your last day on payroll. Your Employer must certify your last day on payroll to FPPA per Rule 1605.

Each of the three packets contained in this application carries its own instructions. Please read them carefully.

All completed packets (three total) must be received by FPPA before you will be scheduled for medical examinations by one or more physicians.

As soon as all packets are received, FPPA will process your application as quickly as possible. The determination of disability retirement 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 Benefit Administrator.

Part 1-A General Applicant Information

Last Name _____ First Name _____ Middle 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, (print your 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.

_____ ☐ Police ☐ Fire

Employer's Name *(name of city, town or special district)*

___/___/___ 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 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

**If any current disability benefit is related to military service, please provide a copy of the VA Disability Decision Letter listing the conditions for which your benefit was granted.*

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 leave days, paid or unpaid, you used in the last 12 months of your employment 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 of your employment due to this particular condition, please indicate the total number of days used in the last 12 months of employment.

_____ Sick Days Used _____ Vacation Days Used _____ Unpaid Days Taken

_____ Other, please specify _____

Are you currently working elsewhere in any 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 willl terminate. 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 Legal Name	Spouse's Social Security Number	Spouse's Birth Date (month, day, year)
_____	___-___-___	___/___/___

Dependents of Applicant

Please list below the full 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 & Regulations* at FPPAco.org for the definition of dependent children.

Child's Legal Name	Social Security Number	Birth Date (month, day, year)	*Is the applicant's household the permanent address of this child?* Yes	No
_____	___-___-___	___/___/___	☐	☐
_____	___-___-___	___/___/___	☐	☐

Please list below the full names and birth dates of any of your children of any age or marital status who are unable to provide for themselves due to mental or physical incapacitation.

Child's Legal 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.*):

_____ ☐ Female ☐ Male _____-_____-_____
Beneficiary's Full Legal Name — Beneficiary's Social Security 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 before a notary public:

_____ _____ /_____ /_____
Applicant's Full Legal Signature — Date

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

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 a Benefit Administrator at the telephone number listed on the front of this application.

- ☐ Your birth certificate and valid 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 is not 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 valid driver's license
- ☐ Your beneficiary's birth certificate and valid 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, stepchildren, and unrelated children living in your household if you have the right to claim the children as dependents in federal income tax filings
- ☐ A provider'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 provider's statement certifying that one or more children is unable to provide for themselves due to physical or mental incapacitation and their birth certificate(s) if the incapaciated child is over 23 years of age
- ☐ If you participate in a money purchase plan, including a hybrid retirement 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) and copies of documentation showing the dates of any required distributions from your retirement plan.

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

Part 1-E FPPA Records and Medical Information Release

Dear Applicant,

FPPA's confidential information policy prohibits us from releasing 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 *FPPA 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 & 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 _____ } 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

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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 Provider. (If you are being treated by more than one Provider, please copy this packet and submit one copy to each Provider. See special instructions on the medical release contained herein.)

To the applicant's provider:

The applicant named in Part 2-A below is in the process of applying for FPPA disability retirement. Because you are the applicant's personal provider, FPPA requires your opinion regarding the applicant's medical condition.

After reviewing FPPA's definitions of disability and the applicant's statement concerning their condition on Part 2-B of this packet, please complete Part 2-C. **If applicable, please provide a treatment plan, including treatment, counseling and/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 the completed Packet 2, medical records relevant to the claimed condition, and treatment plan(s), if applicable, to the applicant.

Each applicant for FPPA disability status may be examined by one or more independent medical examiners appointed by FPPA. Your detailed diagnosis helps us match the applicant with examiners in relevant medical fields.

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 provider(s) who have examined or treated you for the condition(s) for which you are now claiming disability. You must submit a *Provider's Statement of Disability* (see Pages 4-5) for each provider listed who has treated you for the claimed condition.

Please submit supporting medical documentation for each condition listed.

2. Please state specifically:
   - The disability or medical condition(s) that you believe prevents or limits your ability to perform your job duties;
   - The circumstances surrounding the onset of your injury of illness;
   - When the injury occurred or when the condition was diagnosed;
   - The date on which your condition began to affect your ability to perform your job; and
   - 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 the questions you are answering throughout.

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 CDs to all of the appointments with the FPPA independent medical examiner(s).

☐ 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 briefly describe 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 provider:
The Fire & 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 there 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.

Providers, 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 Provider's Statement of Disability

Name of Applicant _____

I, (print your name) _____,

hereby certify that I am duly licensed to practice my specialty of _____

in the State of _____

Type of Licensure: _____

I further certify that I have:

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

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

I last examined the above-named applicant on: _____ /_____ /_____
(Month, Day, Year)

Or, ☐ Performed a clinical consultation on the above-named applicant on:

_____ /_____ /_____
(Month, Day, Year)

☐ Independent Medical Evaluation/Examination ☐ Review of medical records

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: _____

In your opinion, does one or more of the diagnosis above have a casual relationship to the applicant's occupation? If so, please list and indicate relationship.

If the applicant were to follow a treatment plan, what amount of time should treatment be provided prior to an evaluation to establish the ability for the applicant to return to work, without restrictions, in the position described in the official job description provided by the Employer?

Recommended treatment plan (e.g. consultations, counseling, therapy, or other treatments):

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

Please explain your rational for your opinion on the disability level elected.

Print Provider's Name and Credentials

Provider'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 provider:
This medical release is for your files and applies only to the application for disability retirement by the below-named first responder. 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 Benefit Administrator 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 Provider 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 Providers must examine such records and information to evaluate my application for disability retirement.

Applicant's Full Legal Signature _____ Date _____

Required Notarization

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

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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 in a timely manner. Once you have completed all packets, you should submit your entire application to FPPA. Please retain a copy 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 Benefit Administrator.

A review of this application cannot be conducted 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 copy for your files.

Your cooperation is greatly appreciated.

Part 3-A General Applicant Information

Last Name _____ First Name _____ Middle 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 ☐ Workers' 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, short-term disability, and other types of compensation. Do not include vacation pay.

_____

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

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

5. Please indicate below how many days the applicant used in the last 12 months of employment 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 of employment due to this particular condition, please indicate the total number of days the applicant has used in the last 12 months of employment.

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

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

10. Was the applicant'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 applicant'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 listed 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?

☐ Local defined benefit plan ☐ Statewide Money Purchase Plan ☐ Statewide Retirement Plan
☐ Local money purchase plan ☐ Colorado Springs New Hire Plan ☐ Other: _____
Please indicate.

15. 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 or hybrid 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 **local 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 from their **money purchase plan**? ☐ Yes ☐ No

a. If "yes," please provide a copy of the statements showing the amounts and dates of 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 and Salary Certification

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

The last day on the payroll for the purpose of filing the application may include any or all accrued leave or vacation if the employee has remained on the Employer's payroll while exhausting such leave.

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 duty, or modified duty; or pay for accumulated leave that is being exhausted (not paid in a lump sum); or pay due to donated time from 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 request this information, if needed, after making a benefit determination.

3. If the applicant has already terminated employment, state the reason for the separation and attach any available documentation, such as a termination letter, resignation letter, retirement notice, or other records reflecting the reason employment ended.

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 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 their rank or grade unless the applicant is 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/was the applicant required to regularly perform all of the job duties stated on the enclosed job description?

☐ Yes ☐ No

1. Pursuant to Section 31-31-810(2), *Colorado Revised Statutes*, if FPPA determines that an applicant 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 their prior position, the Employer shall thereafter pay benefits to the applicant as if the applicant had been determined occupationally disabled by FPPA. 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 Acknowledgment and Certification

I certify that I have reviewed and completed this Packet 3 of the FPPA Disability Retirement Application for the Member named in Part 3-A.

Signature of Authorized Personnel

Title

Print Name

City/Town or F.P.D.

Mailing Address

City, State, Zip Code

Phone Number

Email Address

_____ /_____ /_____

Date