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	**Disability Retirees**
Who Are Applying For	**Change in Disability Retirement Status**
Under The	**Statewide Death & Disability Plan**
	This packet applies to: **Disability retirees who are applying for a change in disability retirement status.** **Please remember:** • Have your physician(s) complete pages 4 and 5; • Have your signature notarized on the *Medical Information Release;* and • Submit medical records to support your claim. **Questions?** Contact an FPPA Benefit Administrator at the phone numbers listed above. **Send all completed forms to:** FPPA Benefit Administrators at the address listed above. *For your records, please make copies of all completed forms 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 — 1 page
☐	Application for Change in Disability Status — 6 pages

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Before You Apply

This memo, together with the FPPA Application for *Change in Disability Status*, explains the steps required to apply for a change in disability status.

Certain time limits apply:

- If you were granted a Temporary Occupational Disability, you may apply for a Permanent Occupational Disability or Total Disability within five years from your retirement date (the day after your last day on the Employer's payroll). However, you must submit your application at least 180 days before the end of this five-year period.
- If you were granted a Permanent Occupational Disability, you may apply for a Total Disability within five years from your retirement date (the day after your last day on the Employer's payroll). However, you must submit your application no later than the last day of this five-year period.

The application consists of six pages. You will complete pages 1-3 and page 6 regarding your initial disability claim and the condition for which you are now requesting a change in disability status.

Pages 4 and 5 will be completed by your physician(s). If you have more than one physician, you may copy these pages. Be sure to include the *Physician's Instructions* on the bottom of page 3. With the application, please submit medical records to support your claim. These medical records should not include records previously submitted to FPPA. If any information is missing, FPPA will contact you.

Once FPPA has received your complete application, the Death & Disability Review Committee (DDRC) will determine whether to grant a change in disability status or to refer you for examination by one or more physicians.

If the DDRC determines that you must be examined by one or more physicians, the FPPA appointment scheduler will contact you to schedule your appointment(s). After your appointment(s), each physician will submit a written report stating whether they believe your disability status has changed (in accordance with the FPPA definitions of disability).

Once FPPA has received the physician reports, the DDRC may deny or grant the change in disability status. If the DDRC denies the change in disability status, you may file a written request for an evidentiary hearing.

Please call an FPPA Benefit Administrator if you have questions or concerns at (303) 770-3772 or (800) 332-3772, ext. 6300.

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APPLICATION FOR CHANGE IN DISABILITY STATUS

INSTRUCTIONS

To the applicant:

You may apply for a change in disability status as long as you apply within the timeframes outlined below:

✔ FPPA may grant a change in disability status from a Temporary Occupational Disability to either a Permanent Occupational Disability or a Total Disability. This application **must** be completed and submitted to FPPA **no later than 180 DAYS PRIOR to the end of five years from your disability retirement date.**

✔ FPPA may grant a change in disability status from a Permanent Occupational Disability to a Total Disability within five years from your disability retirement date. This application **must** be completed and submitted to FPPA **no later than the last day of the end of the five-year period.**

Your disability retirement date is the day following your last day on your Employer's payroll.

Please complete Parts A and B. You must also complete and sign Part D in the presence of a notary public. Forward a copy of the application to your personal physician(s) for completion of Part C.

When Part C and your medical records are returned to you, submit the entire application packet to FPPA. Please retain a copy of your application for your files.

To the applicant's physician:

The applicant named in Part A below has applied to FPPA for a change in their disability status. FPPA requires your opinion, as the applicant's personal physician, on the applicant's medical condition.

The applicant is currently receiving a:

- ☐ Temporary Occupational Disability
- ☐ Permanent Occupational Disability

After reviewing FPPA's definitions of disability and the applicant's statement concerning their condition on Part B of this application, please complete Part C. Additional information is provided on page 3.

The Medical Information Release (Part D) is for your files.

Each applicant may be examined by one or more physicians appointed by FPPA.

We greatly appreciate your cooperation.

PART A: GENERAL APPLICANT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Mailing Address _____ Apt. # _____

City _____ State _____ ZIP Code _____

Home Phone _____ Cell Phone _____ Email Address _____

Social Security Number _____ Disability Retirement Date _____ Department _____

PART B: APPLICANT'S STATEMENT OF DISABILITY

To be completed by the applicant:

1. On_____, you claimed a disability for the following condition(s):
   mo / day / yr

   _____

   _____

   _____

2. (a) Please list the condition(s) for which you are now claiming a change in disability status:

   _____

   _____

   _____

   (b) Please list the name(s) of the physician(s) who have examined and/or treated you for the condition(s) listed in 2a:

   _____

   _____

(c) 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. If you are scheduled for appointments with one or more physicians assigned by FPPA, be sure to take the films or CDs to **all** the appointments.

☐ X-ray ☐ MRI ☐ Radiologic scan ☐ CT scan ☐ Ultrasound ☐ EKG

3. Please describe, in your own words, why you believe your current FPPA disability status should be changed.

   _____

   _____

   _____

4. If applicable, please list employment history **since receiving your initial disability award,** including dates, type of work and salary. (Please list most recent position first.) Attach additional pages as needed.

   _____

   _____

5. What efforts have you made since being awarded disability benefits to rehabilitate, retrain, or otherwise improve your ability to perform work or other substantial gainful activity? Attach additional pages as needed.

   _____

   _____

_____ _____

Applicant's Full Legal Signature Date

PHYSICIAN'S INSTRUCTIONS

To the physician:

The Fire & Police Pension Association offers two types of disability retirement: **Occupational Disability** and **Total Disability.**

✔ **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. Assigned duties means those specific tasks or jobs that a Member is required to **regularly** perform designated by the Employer for a particular position within a job classification.

Within the **Occupational** category, there are two subcategories: 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 C below, please submit a typewritten medical history and diagnosis for the applicant identified in Part A. If the applicant was hospitalized after the date of the initial disability award, please include dates of hospitalization. A signed and dated medical history, listing diagnosis, documented by laboratory results and/or X-rays, may be attached to this packet in lieu of a detailed medical report.

Please return Part C and medical records to the applicant.

PART C: PHYSICIAN'S STATEMENT OF DISABILITY

I, (print your name)_____, hereby certify that I duly

licensed to practice my specialty of_____ in the State of _____ .

I further certify that I have:
Check one:

☐ Professionally attended the applicant over the time period from:

_____ / _____ / _____ to _____ / _____ / _____; or
mo day yr mo day yr

I last examined the applicant identified in Part A on _____ / _____ / _____

OR

☐ Performed a clinical consultation on the applicant on: _____ / _____ / _____
mo day yr

- ☐ Independent Medical Evaluation/Examination
- ☐ Review of medical records

I further certify that I have found the injuries, infirmities, diseases, or disabilities of the applicant named in Part A to be as follows *(please type or print legibly)*:

Diagnosis:_____

_____

_____

_____

If additional space is needed, please attach separate sheets as necessary.

☐ Check here if an additional sheet is attached.

Based on the disability definitions given on page 3, please indicate, in your opinion, which FPPA disability classification below applies to the applicant identified in Parts A and B of this application.
Please mark **only one** box.

☐ Temporary Occupational Disability ☐ Permanent Occupational Disability ☐ Not Disabled
☐ Total Disability

_____ _____
Provider's Signature Date

_____
Print Physician's Name and Credentials

_____ _____
Mailing Address Phone

_____
Telephone

APPLICATION FOR CHANGE IN DISABILITY STATUS
PART D: MEDICAL INFORMATION RELEASE

To the physician:
This medical release is intended for your files and applies only to the application for change in disability status by the below-named applicant. 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 (303) 770-3772 or (800) 332-3772 or at FPPA's offices at 7979 East Tufts Ave., Suite 900, Denver, Colorado 80237.

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 application.

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

I, (print full legal name) _____, have applied to FPPA for a change in disability status. 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 as part of this 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 physician(s) must examine such records and information to evaluate my application for a change in disability status.

_____ _____
Applicant's Full Legal Signature Date

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

REQUIRED NOTARIZATION

STATE OF _____

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