

Fire & Police Pension Association of Colorado

FPPAco.org • 5290 DTC Parkway, Suite 100 • Greenwood Village, Colorado 80111-2721
(303) 770-3772 in the Denver Metro area • (800) 332-3772 toll free nationwide • (303) 771-7622 fax

<i>For</i>	FPPA Active Members	
<i>Who Are Applying For</i>	Disability Retirement	
<i>Under The</i>	Statewide Death & Disability Plan	
	<p>This Packet Applies To: Active members who are applying for disability retirement.</p> <p>Please Remember:</p> <ul style="list-style-type: none">• read the Step By Step booklet carefully prior to completing the application,• have your signature notarized where required, and• submit the necessary documentation. <p>Questions? Contact an FPPA Death & Disability Benefit Coordinator at the phone numbers listed above.</p> <p>Send all completed forms to: FPPA Death & Disability Benefit Coordinator at the address listed above.</p> <p><i>Please make copies for your files of the forms you fill out prior to submitting them to FPPA.</i></p>	
Forms & Publications	<p>In this application packet you will find the following forms and information needed to process your application. <i>Check the box to the LEFT as you complete each of the forms.</i></p>	# of Pages
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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 Chapters 4 and 5 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.

Upon receipt of the application, FPPA staff will review it. If any information is missing you will be contacted. Once complete, the application will be sent to FPPA's contracted Medical Advisor. The Medical Advisor will review it and determine which three physicians will examine you. The Medical Advisor's secretary will contact you and schedule your three medical appointments. You will then receive an appointment confirmation letter from FPPA.

After you have attended the appointments, each physician will submit a written report stating whether he/she feels you meet the definition of temporary occupational disability, permanent occupational disability, total disability or not disabled (in accordance with the FPPA definitions of disability). By law, at least two of the three examining physicians must find you disabled in order for the FPPA Board of Directors to grant you a disability benefit. The physicians may also address the issue of whether or not your condition is the result of an on-duty injury or illness.

Once FPPA has received the physician's reports, we will schedule your disability hearing for the next available Death & Disability Review Committee Meeting (DDRC).

The DDRC will make a determination regarding your disability status. In some cases, an application may be referred for further review. You will receive written notification of the decision regarding your application. If you disagree with any aspect of the decision, you may request an evidentiary hearing.

If it is determined that you are disabled, and if you applied for on-duty disability status, FPPA will address the on-duty issue. FPPA can either grant or deny the on-duty status, or if the DDRC denies the on-duty status, you may file a written request for an evidentiary hearing. The on-duty hearing will not cause your disability benefit payment to be delayed.

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.

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 a 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 506.011 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 web site at www.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. Per FPPA Rules & Regulations - Rule 404.04, FPPA will accept an application within 180 days after your last day on payroll. Your employer must certify your last day on payroll to FPPA.

Each of the three packets contained in this application carries its own instructions; please read them carefully. In Packet 1; Part 1-C, Part 1-E and in Packet 2; 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 be periodically reexamined.

Part 1 - A General Applicant Information

Last Name _____		First _____	Initial _____
Mailing Address _____		Apt. # _____	
City _____	State _____	Zip _____	
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 Statutes*, 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* \$ _____ Rank _____
(gross annual salary)

Are you Single? ☐ Yes ☐ No

If not, 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 www.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 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 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 defined benefit from a local Colorado defined benefit pension plan? ☐ Yes ☐ No

► 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 www.FPPAco.org for the definition of dependent children.

Is the member's household the permanent address

Child's Name	Social Security Number	Birth Date (month, day, year)	Is the member's household the permanent address of this child? Yes / No
_____	_____-_____-_____/_____/_____/_____/_____/_____	_____/_____/_____/_____/_____/_____/_____/_____	<input type="checkbox"/> <input type="checkbox"/>
_____	_____-_____-_____/_____/_____/_____/_____/_____	_____/_____/_____/_____/_____/_____/_____/_____	<input type="checkbox"/> <input type="checkbox"/>

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 Social Security Number _____

_____/_____/_____
Beneficiary's Birth Date (mo, day, year) Relationship of beneficiary to applicant _____

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

(_____) _____ - _____
Beneficiary's Home Phone Number Beneficiary's Alternate Phone Number

Beneficiary's Mailing Address _____ Apt. No. _____

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

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 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, 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, 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

Please Note

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

Required Signature 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

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

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 your 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.)

[illegible]

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 documents below.

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

Required Signature

Applicant's Full Legal Signature

Date

To the physician:

Occupational Disability

► **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.

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.

☐ Examined the above-named applicant on _____ / _____ / _____
(MM / DD / YYYY)

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

(_____) _____ - _____
 Telephone Name of Applicant

DISABILITY RETIREMENT APPLICATION**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 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 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

Please Note

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

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



Fire and Police Pension Association
5290 DTC Parkway • Suite 100
Greenwood Village, Colorado 80111
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www.FPPAco.org

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

_____/_____/_____
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. ____ / ____ / ____

- | | Yes | No |
|---|--------------------------|--------------------------|
| 2. Is the applicant receiving any type of special compensation while on special injury or disability status?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 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.)
<div style="border-bottom: 1px solid black; height: 1.2em; margin-top: 5px;"></div> | | |
| 3. Is the applicant receiving full pay? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Was this injury/illness documented with the department?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 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.
<div style="display: flex; justify-content: space-around; margin-top: 5px;"> ____ Sick Days Used ____ Vacation Days Used ____ Unpaid Days Taken </div> | | |
| 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.
<div style="display: flex; justify-content: space-around; margin-top: 5px;"> ____ Sick Days Used ____ Vacation Days Used ____ Unpaid Days Taken </div> | | |
| 6. Was a Workers' Compensation claim filed in relation to this injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Who is your Workers' Compensation carrier (i.e. self-insured or separate carrier)?
<div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 45%;"> <div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> </div> <div style="width: 50%;"> <div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> </div> </div> | | |
| 8. Has Workers' Compensation accepted liability? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending <input type="checkbox"/> N/A | | |
| 9. Was a Statewide Standard Health History Form filed on this applicant with FPPA?
(This was required for members hired on or after 9/1/89.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. To your knowledge, was the condition caused by: | | |
| • addiction to a controlled substance?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • engaging in any act for which the applicant has been convicted of a felony? | <input type="checkbox"/> | <input type="checkbox"/> |
| • an intentionally self-inflicted injury?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |

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.

	Yes	No
12. Does the employer believe there is an additional basis/condition to be assessed for disability?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please specifically state the condition. _____		
<p>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.</p>		
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? <input type="checkbox"/> Statewide Defined Benefit Plan		
<input type="checkbox"/> local defined benefit plan <input type="checkbox"/> Statewide Money Purchase Plan <input type="checkbox"/> Statewide Hybrid Plan		
<input type="checkbox"/> local money purchase plan <input type="checkbox"/> Colorado Springs New Hire Plan <input type="checkbox"/> Other _____		<i>Please indicate.</i>
15. If the applicant was hired after January 1, 1997 please answer the following. Who is paying the Death & Disability Contribution?		
Employee _____% <input type="checkbox"/> Pre-tax <input type="checkbox"/> 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?	<input type="checkbox"/>	<input type="checkbox"/>
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 , <u>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 on payroll.</u>		
18. Has the member taken a distribution from his/her money purchase plan ?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>

PART 3 - C PAYROLL DATE & SALARY CERTIFICATION

FPPA will accept an application for disability retirement within 180 days after the applicant's last day on the payroll. The last day on the payroll for the purpose of filing the application may or may 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 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 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 www.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.

1. Is the applicant required to **regularly** perform all of the job duties stated on the enclosed job description? ☐ Yes ☐ No

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

(_____) _____ - _____
Phone

Email

Date