



# Application Packet Cover Sheet

## 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

For	<b>Disability Retirees</b>	
Who are	<b>Applying for a Change in Disability Retirement Status</b>	
	<p><b>This Packet Applies To:</b> Disability retirees who are applying for a change in disability retirement status.</p> <p><b>Please Remember:</b></p> <ul style="list-style-type: none"><li>• have your physician(s) complete pages 4 and 5,</li><li>• have your signature notarized on the <i>Medical Information Release</i>, and</li><li>• submit medical records to support your claim.</li></ul> <p><b>Questions?</b> Contact an FPPA Death &amp; Disability Benefit Coordinator at the phone numbers listed above.</p> <p><b>Send all completed forms to:</b> FPPA Death &amp; 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>	
<b>Forms &amp; Publications</b>	In this application packet you will find the following forms and information needed to process your application. <b><i>Check the box to the LEFT as you complete each of the forms.</i></b>	<b># of Pages</b>
	Instruction Memo	1
<input type="checkbox"/>	Application for Change in Disability Status	6

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**Instructions Memo**

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This memorandum, together with the *FPPA Application for Change in Disability Status*, will explain 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 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 no later than 180 days prior to the expiration 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 are to complete pages 1-3 and page 6. The information requested is regarding your initial disability claim and the condition for which you are now requesting a change in disability status.

Pages 4 and 5 are to be completed by your physician(s). If you have more than one physician, you may photocopy 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, you will be contacted.

Once FPPA has received your complete application, the Death & Disability Review Committee (DDRC) will make a determination either to grant a change in disability status, or to refer you for examination by a panel of physicians.

If it is determined that you are to be examined by a panel of physicians, the FPPA Medical Advisor's secretary will contact you and schedule your 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 believes your disability status has changed (in accordance with the FPPA definitions of disability).

Once FPPA has received the physician's 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 feel free to call if you have questions or concerns. You may reach an FPPA Death & Disability Benefit Coordinator at 303-770-3772 or 1-800-332-3772.

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## APPLICATION FOR CHANGE IN DISABILITY STATUS

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### INSTRUCTIONS

#### ■ To the applicant:

You may apply to have your disability status changed 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.**

The disability retirement date is the day following your last day on your employer's payroll.

Please complete Part A and Part 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 his/her disability status. FPPA requires your statement, 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 his/her condition on Part B of this application, please give your statement on 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 a panel of physicians appointed by FPPA.

Your cooperation in this manner is greatly appreciated.

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**PART A: GENERAL APPLICANT INFORMATION**

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Last Name	First	Initial
Mailing Address		Apt. #
City	State	Zip
Home Phone	Cell Phone	Work Phone
Social Security Number	Disability Retirement Date	Department

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**PART B: APPLICANT'S STATEMENT OF DISABILITY**

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**To be completed by the applicant:**

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

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

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

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(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 the FPPA examining physicians, be sure to take the films or CD's to **all** the appointments.

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

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

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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.

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Applicant's Full Legal Signature

Date

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## PHYSICIAN'S INSTRUCTIONS

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### ■ To the physician:

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

- ✓ **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 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 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.

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## PART C: PHYSICIAN'S STATEMENT OF DISABILITY

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I, (insert your name) \_\_\_\_\_, hereby certify that I am a physician duly licensed to practice medicine in the State of \_\_\_\_\_.

I further certify that I have:

Check one:

☐ Professionally attended the applicant identified in Part A from

\_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_; or  
mo day yr mo day yr

☐ Examined the applicant identified in Part A on \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mo day yr

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
- ☐ Total Disability
- ☐ Not Disabled

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Physician's Signature

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Date

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Physician's Name (please print or type)

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Mailing Address

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Telephone

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## **APPLICATION FOR CHANGE IN DISABILITY STATUS**

### **PART D: MEDICAL INFORMATION RELEASE**

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**To the Physician:**

This medical release is 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 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 application for change in disability status.

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

I, (insert 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 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 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.

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## **REQUIRED NOTARIZATION**

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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