



OKLAHOMA LAW ENFORCEMENT
— RETIREMENT SYSTEM —

Application for Disability Benefit

I, _____, am making application to the Board of Trustees of the Oklahoma Law Enforcement Retirement System, "OLERS", do hereby request to terminate my employment with my agency and start receiving a monthly disability pension as I am no longer able to perform the duties of my occupation or service for which I am qualified and I am unable to perform another service to my agency. Also, I attest the reason I am leaving my agency is wholly due to my disability and I have been informed by my agency there is no other service, regardless of occupation, I can provide to the agency. (Oklahoma Statute Title 47, Sections 2-300(11) and 2-305; OAC 395:10-1-13)

_____ I understand if the OLERS Board determines that my application is fraudulent the OLERS Board will
(initial) prosecute under Title 47, Section 2-312.

_____ I understand if I am applying for a service connected PTSD disability, I MUST show that I have notified my
(initial) agency that I believe that PTSD may have occurred AND I will provide the incident report and/or evidence of job related condition. Also, I understand that OLERS will not send me for medical evaluation without this information.

_____ I understand the OLERS Board reserves the right to require a polygraph test in connection with my claim of
(initial) disability.

I am declaring that my disability is: (check one)

Non-Service Related

Service Related

Applicant Information

Agency Currently Employed With _____

SSN _____ Birth Date _____

Driver's License Number _____ Current Age _____

Nature of Injury _____

Service End Date _____ Pension Start Date _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email _____

Admin _____
Actions _____ Data Entry _____ Reviewed _____ Approved _____

Applicant's Name _____

Disability Retirement Questionnaire (OAC 395:10-1-13)

THE INFORMATION PROVIDED IN THIS APPLICATION IS NECESSARY FOR THE BOARD TO MAKE AN INFORMED DECISION CONCERNING YOUR APPLICATION FOR DISABILITY. FAILURE TO COOPERATE FULLY BY NOT ANSWERING ALL QUESTIONS COMPLETELY, TRUTHFULLY AND ACCURATELY CAN RESULT IN DELAYS, DENIAL OF YOUR CLAIM, OR FRAUD PROSECUTION.

Background Information:

1. Educational background? (check one)
 - GED
 - High School
 - Some College
 - College
 - Post-Graduate
 - Doctorate
2. Address where you worked for your employer?
 - a. Address _____
City _____ State _____ Zip _____
 - b. Phone Number _____
3. Last day on payroll for your employer? _____
4. Position or Title held with your employer? _____
5. What were your actual duties for your employer? _____
6. How long did you work in this position? Years _____ Months _____
7. Did you hold a previous position(s) with your current employer? Yes No
 - a. If yes, how long were you in each position?
 - i. Position Title _____ Years _____ Months _____
 - ii. Position Title _____ Years _____ Months _____
 - iii. Position Title _____ Years _____ Months _____
8. Are you currently employed outside of your employing agency? Yes No
 - a. If yes, give the name, address and telephone number of each current employment (including self-employment) other than the employment which allows you to be a member of this System.
 - i. Employer Name _____
 1. Address _____
City _____ State _____ Zip _____
 2. Phone Number _____
 - ii. Employer Name _____
 1. Address _____
City _____ State _____ Zip _____
 2. Phone Number _____

Applicant's Name _____

Disability Retirement Questionnaire (OAC 395:10-1-13)

Background Information (continued):

9. Have you ever received any type of medical or disability retirement? Yes No
- a. If yes, please provide the name, written documentation, nature of the disability, address of the entity from which you receive the retirement, and the amount or amounts of retirement received.
- i. Medical/Disability Retirement Name _____
 - ii. Nature of Medical/Disability Awarded _____
 - iii. Retirement Amount _____
 - iv. Address _____
City _____ State _____ Zip _____
 - v. Written documentation attached? Yes No
10. Have you ever been awarded disability from the Military, State or Social Security? Yes No
- a. If yes, please provide the nature of the disability, the amount and written documentation.
- i. Nature of Medical/Disability Awarded _____
 - ii. Disability Amount _____
 - iii. Written documentation attached? Yes No
11. Have you ever received Worker's Compensation benefits? Yes No
- a. If yes, please provide the name, written documentation, nature of the injury, address of the entity from which you receive the retirement, and the amount or amounts of retirement received.
- i. Company/Agency _____
 - ii. Nature of injury Awarded _____
 - iii. Award Amount _____
 - iv. Written documentation attached? Yes No
12. Have you ever been awarded a personal injury settlement? Yes No
- a. If yes, please provide the nature of the injury, the amount and written documentation.
- i. Nature of Injury Awarded _____
 - ii. Award Amount _____
 - iii. Written documentation attached? Yes No
13. Have you ever been awarded a monetary judgment as a result of a personal injury accident? Yes No
- a. If yes, please provide the nature of the injury, the amount and written documentation.
- i. Nature of Injury Awarded _____
 - ii. Award Amount _____
 - iii. Written documentation attached? Yes No

Applicant's Name _____

Disability Retirement Questionnaire (OAC 395:10-1-13)

Current Disability Information:

14. Why are you currently asking the OLERS for a non-service or service related disability retirement? _____

15. State which part or parts of your body have been injured for which you are seeking disability? _____

16. Is this claimed disability related or caused by your employment? Yes No

a. If yes, why or how?

17. Is this disability unrelated to your employment? Yes No

a. If yes, why or how? _____

18. Describe in detail the injury you claim is the basis for your OLERS disability retirement.

19. Give details concerning the source or cause of the problem which is causing you to seek a disability retirement? _____

Applicant's Name _____

Disability Retirement Questionnaire (OAC 395:10-1-13)

Current Disability Information (continued):

20. Describe the incident(s) which you assert caused your injury? _____

a. When did this incident(s) occur? _____

b. Was this incident(s) reported to your employer? Yes No

i. How? _____

c. Was there a written report made to document this incident(s)? Yes No

i. If yes, is all the written documentation attached? Yes No

d. When did you first seek medical treatment for the injury? _____

e. Please give the name and address of the treatment provider, date or dates of treatment, and the nature of the treatment.

i. Treatment Provider _____ Date of Treatment _____

1. Nature of Treatment _____

2. Address _____

City _____ State _____ Zip _____

3. Phone Number _____

ii. Treatment Provider _____ Date of Treatment _____

1. Nature of Treatment _____

2. Address _____

City _____ State _____ Zip _____

3. Phone Number _____

f. Did you have any follow up evaluations or treatment by other physicians or medical personnel? Yes No

i. If yes, please give the name and address of the treatment provider, date or dates of treatment, and the nature of the treatment.

1. Treatment Provider _____ Date of Treatment _____

a. Nature of Treatment _____

b. Address _____

City _____ State _____ Zip _____

c. Phone Number _____

2. Treatment Provider _____ Date of Treatment _____

a. Nature of Treatment _____

b. Address _____

City _____ State _____ Zip _____

c. Phone Number _____

21. Who caused you to see or referred you to see the above-referenced physicians or medical personnel? _____

22. Prior to the date of the incident which is giving rise to your claim for disability, had you ever sustained any similar injury or suffered similar problems? Yes No

a. If yes, please provide the details. _____

Applicant's Name _____

Disability Retirement Questionnaire (OAC 395:10-1-13)

Current Disability Information (continued):

23. Please provide a list of all medical personnel, doctors, physicians, chiropractors, etc., you have seen in connection with the medical problem or injury which is the basis for your claim along with their name, address, telephone number and the date and reason for your visit, examination or treatment.

- a. Treatment Provider _____ Date of Treatment _____
 - i. Nature of Treatment _____
 - ii. Address _____
City _____ State ____ Zip _____
 - iii. Phone Number _____
- b. Treatment Provider _____ Date of Treatment _____
 - i. Nature of Treatment _____
 - ii. Address _____
City _____ State ____ Zip _____
 - iii. Phone Number _____

24. List the names of any person who has personal knowledge of your accident or disability which is the basis for your claim. _____

25. Following treatment of your injury, has the treating physician or any doctor released you to return to work? Yes No

- a. Did this doctor place any work restrictions on you? Yes No
 - i. If yes, what were the work restrictions placed upon you by this doctor? _____

- b. Please submit the name and address of this doctor
 - i. Treatment Provider _____ Date of Treatment _____
 - 1. Nature of Treatment _____
 - 2. Address _____
City _____ State ____ Zip _____
 - 3. Phone Number _____

c. Written documentation attached? Yes No

26. If you cannot perform the job tasks in your currently assigned position, please state why?

Applicant's Name _____

Disability Retirement Questionnaire (OAC 395:10-1-13)

Current Disability Information (continued):

- 27. If you cannot perform your current job tasks, can you perform any service or occupation for your employer? Yes No
 - a. If yes, what service or occupation _____
- 28. Has your employer told you that you can't return to work? Yes No
 - a. If yes, who told you that you couldn't return? _____
 - b. Why? _____
 - c. When? _____
- 29. Have you filed any type of grievance against your employer as a result of being told you could not return to work? Yes No
 - a. If yes, attach documentation.
- 30. Do you wish to return to work for your employer? Yes No
 - a. If no, explain why? _____

- 31. Between the last day of work performed for your agency employer and today, have you performed and/or been paid for any other type of employment? Yes No
 - a. If yes, When: _____
 - b. Name _____
 - i. Address _____
City _____ State ____ Zip _____
 - ii. Phone Number _____
 - c. Duties: _____
- 32. Since your injury, would you be willing to provide copies of any income, income statements, pay stubs, and your income tax returns including W-2s or 1099? Yes No
 - a. If yes, please produce copies of any income, income statements, pay stubs, W-2s or 1099s from the date of your injury until present. Copies attached? Yes No
- 33. What efforts have you taken to attempt to rehabilitate yourself following your injury?

 - a. Please submit any documents which show your efforts to rehabilitate. Documentation attached? Yes No

Applicant's Name _____

Disability Retirement Questionnaire (OAC 395:10-1-13)

Current Disability Information (continued):

- 34. Do you have any other health problems? Yes No
 - a. In your opinion, have any of these health problems, contributed to your inability to recover fully? Yes No
 - i. If yes, please explain why? _____

 - b. In your opinion, have any of these health problems, contributed to the severity of your injury? Yes No
 - i. If yes, please explain why? _____

 - c. In your opinion, have any of these health problems, actually caused the current injury or medical problem? Yes No
 - i. If yes, please explain why? _____

- 35. Are there any personal problems in your life which are contributing to your existing injury or claimed disability? Yes No
 - a. If yes, please explain why? _____

- 36. Are there any personal problems in your life which have caused your existing injury or claimed disability? Yes No
 - a. If yes, please explain why? _____

Applicant's Name _____

Other Information (Please Initial Each Statement)

- _____ I understand if I am reemployed by a state agency in a position which is covered by OLERS my retirement payments shall be suspended until I retire and I am no longer employed by a state agency in a position covered by the OLERS.
- _____ I understand it is my responsibility to inform OLERS in writing of any changes in my disability which would enable me to return to full duty and I understand failure to do so will result in fraud prosecution and repayment of benefits I received.
- _____ I understand the OLERS Board and will investigate any and all disability claims to the fullest extent allowed. (OLERS v. Shryrock)
- _____ I understand as a disability retirement the IRS may investigate my disability claims to determine if they meet the Internal Revenue Code and if found fraudulent I may face Federal prosecution, fines, penalties and interest.

Signature and Notary

Wherefore, applicant requests that he/she be granted a monthly pension in accordance with Oklahoma Statute Title 47, Sections 2-300 through 2-315 to be paid from the Oklahoma Law Enforcement Retirement System in accordance with the laws of the State of Oklahoma.

Date _____

Applicant's Signature

The Applicant stated above has attested that he/she has read this application, knows the contents thereof, and that the statements contained therein are true and correct.

Subscribed and sworn before me on _____.

State of _____

Notary Signature _____

County of _____

Notary Title (and Rank) _____

My Commission Expires on _____

Commission # _____

(seal)

Submission Information

Completed form can be sent to OLERS via:

Mail: 421 N.W. 13th, Suite 100, Oklahoma City, OK 73103

Fax: (405) 522-5004

Email: forms@olers.ok.gov