

Office of the New York State Comptroller

New York State and Local Retirement System
Employees' Retirement System
Police and Fire Retirement System
110 State Street, Albany, New York 12244-0001

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Application for Police & Fire Retirement for Disability Incurred in Performance of Duty

PF 6047

(Rev. 12/13)

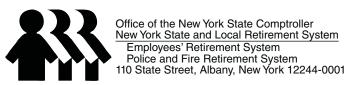
INSTRUCTIONS: Please print plainly or type. The application must be signed on reverse side. Please call our Call Center at 1-866-805-0990 if you need help completing this application.

INFORMATION ABOUT YOU					
1. NAME 2. SEX:			3. SOCIAL SECURITY NUMBER* XXX-XX-		
4. ADDRESS			5. REGISTRATION NUMBER		
			6. DATE OF BIRTH / /		
7. TELEPHONE NUMBERS: HOME	()		8. EMPLOYER		
WORK () CELL	()				
9. PAYROLL TITLE			10. LENGTH OF SERVICEYearsMonths		
11. PAYROLL STATUS: On Payroll & Receiving Salary?					
12. FOR UNITED STATES TAX WITHHOLDING A I AM A: U.S. CITIZEN RESIDEN		RPOSES (PI		c),	
13. I AM PERMANENTLY DISABLED BECAUSE OF THE FOLLOWING MEDICAL CONDITION(S): (Use additional sheets if required)					
14. I HAVE BEEN TREATED BY THE FOLLOWING DOCTORS: (Use additional sheets if required)					
Primary Care Physician	Doctor			octor	
Internal Med/Family Practitioner	Medical Speciality		Me	edical Speciality	
Street	Street		Str	reet	
City, State and Zip Code	City, State and Zip Code		Cit	y, State and Zip Code	
Doctor	Doctor		Do	octor	
Medical Speciality	Medical Speciality		Me	edical Speciality	
Street	Street		Str	reet	
City, State and Zip Code	City, State and Zip Code		Cit	y, State and Zip Code	

15. LIST HOSPITALIZATIONS, IF A	INY. (Use add	itional sneets if required)				
Hospital Dates of Admiss		ssion	Hospital		Dates of Admission	
Street			Street			
City, State and Zip Code			City, State and Zip Code			
Hospital Dates of Admi		Hospital			Dates of Admission	
Street			Street			
City, State and Zip Code			City, State and Zip Code			
16. DATES OF OCCURRENCES, WI (Please describe occurrences in		OCCURRED, AND WORK	LERS' COMPENSATION	NUMBER(S)	ASSIGNED.	
,						
17. THE FOLLOWING PERSON(S)	WITNESSED '	THE OCCURRENCE(S):				
Witness Name		Witness Name		Witness Name		
Date Witnessed		Date Witnessed			Date Witnessed	
Witness Address		Witness Address	tness Address W		Witness Address	
City, State and Zip Code		City, State and Zip Code		City, State and Zip Code		
18. DESCRIPTION OF THE OCCUR			OTHER OCCURRENCES	 THAT MAY B	E RELATED TO YOUR CLAIMED	
DISABILITY. (Use additional she	ets if required					
19. INFORMATION ABOUT YOUR II	NTENDED BE	NEFICIARY	,			
Beneficiary			Relationship to you (if any)			
Street		Date of Birth				
City, State and Zip Code			Sex			
l certify that the information co	ontained on	this form is true.	1			
Applicant Name/Title (Please Print)			Applicant Signature (Sign Name in Full) / Date			
RELATIONSHIP TO MEMBER: (If applicant is not the member or em		☐ Employer ☐ Other		ou to file)		

*NOTE: In accordance with the Federal Privacy Act of 1974 you are hereby advised that disclosure of your Social Security account number is mandatory pursuant to Section 11, 34, 311 and 334 of the Retirement and Social Security Law. Your number will be used in identifying your retirement records and in the administration of the Retirement System.

PERSONAL PRIVACY PROTECTION LAW - The Retirement System is required by law to maintain records to determine eligibility for and calculate benefits. Failure to provide information may interfere with timely payment of benefits. The System may be required to provide certain information to participating employers. The official responsible for record maintenance is the Director of Member Services, NYS and Local Retirement Systems, Albany, NY 12244; 518-474-7736.



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA RS 6429

UTZJ

				(Rev. 4/11)		
Pat	tient Name		Date of Birth	Social Security Number XXX-XX-		
Pat	tient Address					
n ac	my authorized representative, request that health informati coordance with New York State Law and the Privacy Rule of derstand that:					
	This authorization may include disclosure of information relative except psychotherapy notes, and CONFIDENTIAL HIV* Right in item 8(a). In the event the health information described by box in Item 8(a), I specifically authorize release of such info	ELATED IN elow include	FORMATION only if I places any of these types of i	ace my initials on the appropriate line information, and I initial the line on the		
	f I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.					
	I have the right to revoke this authorization at any time by writing to the health care provider(s) listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.					
	Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.					
	THIS AUTHORIZATION DOES NOT AUTHORIZE YOU T ANYONE OTHER THAN THE ATTORNEY OR GOVERN					
	Name and address of health care provider(s) or entity(ies)					
7.	Name and address of person(s) or category of person to w New York State and Local Retirement System, Ma			any NY 12244		
8.	(a) Specific information to be released:			•		
	 Entire Medical Record, including patient histories films, referrals, consults, insurance records, and 	s, office note records ser	s (except psychotherapy nt to you by other health	notes), test results, radiology studies care providers.		
	☐ Other:		Include: (Indicate	by Initialing)		
			Menta	ol/Drug Treatment al Health Information elated Information		
	Authorization to Discuss Health Information					
	(b) By initialing here I authorize		Name of individual health	care provider		
	to discuss my health information with my attorney or g	jovernmenta		·		
	New York State an					
	(Attorney/Firm Name					
9. Reason for release of information:At the request of individualOther:		10. Th	10. This authorization will expire at the completion of the disability retirement application process.			
	If not the patient, name of person signing form:	12. Au	uthority to sign on behalf	of patient:		
	ems on this form have been completed and my questions	about this fo	orm have been answere	d. In addition, I have been provided a		
opy	of the form.					
Sian	ature of patient or representative authorized by law		Date			

^{*} Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.