Office of the New York State Comptroller New York State and Local Retirement System 10 State Street, Albany, New York 12244-0001 Please type or print clearly in blue or black ink	Received Date		Application for Ordinary Disability Retirement for Police and Fire Retirement System Members and Tier 1 & 2 Employee Retirement System Members) RS 6038 (Rev. 11/18)
	Social Security Number [las	st 4 digits	Employees' Retirement System (ERS)
Please return this application to the	Retirement System in an enve	lope ma	rked "Personal and Confidential Mail Drop 7-1"
	print plainly or type. The applica Center at 1-866-805-0990 if you		st be signed on the reverse side. elp completing this application.
INFORMATION ABOUT YOU			
1. Name: (First, Middle Initial, Last) 2. Sex: Image: M Image: First for the second		3. Date of Birth:	
4. Address: (Including Street, City, State a	and Zip Code)		5. Telephone Numbers: HOME ()
			WORK() CELL()
6. Payroll Title:	7. Employer:		8. Length of Service: years months
9. Payroll Status: On Payroll & Receiving	Salary? 🔲 Yes 🗌 No If N	o, Expla	in.
10. I am permanently disabled because of	the following medical condition	s): (Use	additional sheets if required)
11. I HAVE BEEN TREATED BY THE FO	LLOWING DOCTORS: (Use ad	lditional	sheets if required)
Primary Care Physician:	Doctor:		Doctor:
Internal Med/Family Practitioner:	Medical Specialty:		Medical Specialty:
Street:	Street:		Street:
City, State and Zip Code:	City, State and Zip Code:		City, State and Zip Code:
Doctor:	Doctor:		Doctor:
Medical Specialty:	Medical Specialty:		Medical Specialty:
Street:	Street:		Street:
City, State and Zip Code:	City, State and Zip Code:		City, State and Zip Code:

IMPORTANT – You must complete other side



12. LIST HOSPITILIZATIONS, IF ANY: (Use additional sheets if required)			
Hospital:	Dates of Admission:	Hospital:	Dates of Admission:
Street:		Street:	
City, State and Zip Code:		City, State and Zip Code:	
Hospital:	Dates of Admission:	Hospital:	Dates of Admission:
Street:		Street:	
City, State and Zip Code:		City, State and Zip Code:	

13. INFORMATION ABOUT YOUR INTENDED BENEFICIARY:		
Beneficiary:	Relationship to you (if any)	
Street:	Date of Birth:	
City, State, and Zip Code:	Sex:	

I certify that the information on my application is true and complete to the best of my knowledge. I further certify that I am aware that any false statement I knowingly make or permit to be made on this or any record of the Retirement System constitutes a crime punishable by potential incarceration and other sanctions.

Applicant Name/Title (Please Print)	Applicant Signature (Sign Name in Full/Date)
RELATIONSHIP TO MEMBER: Self Employer	POA (copy) Other

(If applicant is not the member or employer, you must submit original documentation that authorizes you to file. A copy of a POA will be accepted.)

*Social Security Disclosure Requirement

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 Sections 11, 34, 311 and 334 of the Retirement and Social Security Law. The number will be used in identifying 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 the 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 and Employer Services, NYS and Local Retirement System, Albany, NY 12244; call toll-free at 1-866-805-0990 or 518-474-7736 in the Albany Area. RS 6038 (Rev. 11/18)

Office of the New	York State	Comptroller
(BN)	/SL	$_RS$

New York State and Local Retirement System 110 State Street, Albany, New York 12244-0001

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

RS 6429

(Rev. 09/18)

Please type or print clearly	
in blue or black ink	

Patient Name: (First, Middle Initial, Last)

Date of Birth:

Received Date

Social Security Number: XXX-XX-

Patient Address: (Including Street, City, State and Zip Code)

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMEMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in item 8(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in item 8(a), I specifically authorize release of such information to the person(s) indicated in Item 7.
- 2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from disclosing 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 (1-888-392-3644) or (212-961-8650). This agency is responsible for protecting my rights.
- 3. 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.
- 4. 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.

5. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 8(b).

6. Name and address of health care provider(s) or entity(ies) to release this information:		
		o whom this information will be sent: Iail Drop 7-1, 110 State Street, Albany NY 12244
films, referrals, co	cord, including patient histories, nsults, insurance records, and re	office notes (except psychotherapy notes), test results, radiology studies, ecords sent to you by other health care providers. Include: (Indicate by Initialing) Alcohol/Drug Treatment Mental Health Information HIV-Related Information
(b) By initialing here	l authorize	to discuss my health
Ini	tials	Name of individual health care provider
information with my at	torney or governmental agency	listed here:
		ocal Retirement System
	(Attorney/Firm Name or G	Government Agency Name)
9. Reason for release of inf At the request of ir Other:		10. This authorization will expire at the completion of the disability retirement application process:
11. If not the patient, name	of person signing form:	12. Authority to sign on behalf of patient:

Signature of patient representative authorized by law

Date

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