Office of the New York State Comptroller			
<b>3</b> NYSLRS			
New York State and Local Retirement System			
110 State Street, Albany, New York 12244-0001			
Please type or print clearly in blue or black ink			
NYSLRS ID			

Received Date			

## Application for 605A

New York State and Local Retirement System 110 State Street, Albany, New York 12244-0001		Accidental Disability (Available for Uniformed Court Officers)		
Please type or print clearly in blue or black ink		RS 6410		
NYSLRS ID	Social Security Number [last 4 digits	Retirement System [check one]  Employees' Retirement System (ERS)  Police and Fire' Retirement System (PFRS)		
	e print plainly or type. The application mull Center at 1-866-805-0990 if you need h			
INFORMATION ABOUT YOU				
1. Is the benefit(s) that you are applying f	or a heart presumption? Yes No			
2. Name: (First, Middle Initial, Last)	3. Sex:	4. Date of Birth:		
5. Address: (Including Street, City, State	and Zip Code)	6. Telephone Numbers: HOME ( )		
		WORK( ) CELL( )		
7. Payroll Title:	8. Employer:	9. Length of Service: years months		
10. Payroll Status: On Payroll & Receivin	g Salary? Yes No If No, Exp	plain.		
11. I am permanently disabled because of	of the following medical condition(s): (Use	e additional sheets if required)		
12. I HAVE BEEN TREATED BY THE FO	OLLOWING DOCTORS: (Use additional	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:		

IMPORTANT - You must complete other side

Medical Specialty:

City, State and Zip Code:

Street:

Medical Specialty:

City, State and Zip Code:

Street:

RS 6410 (Rev. 12/18) (Page 1 of 2)

City, State and Zip Code:

Medical Specialty:

Street:

13. 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:			
14. DATES OF ACCIDENTS (Please describe accident(s)		ND WORKERS' COMPENSATIO	N NUMBER(S) ASSIGNED **:		
15. DESCRIPTION OF THE ACCIDENT(S). ALSO DESCRIBE ANY OTHER OCCURRENCES THAT MAY BE RELATED TO YOUR CLAIMED DISABILITY: (Use additional sheets if required). If there are witnesses to the accident(s), please provide names and contact information on an additional sheet of paper.					
16. INFORMATION ABOUT YO	UR 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 (S	ign Name in Full/Date)		
RELATIONSHIP TO MEMBER:	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.)					
** If Waylons' Commonation banefit	a mambay must apply for them. Apply 1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-	hility Detirement Denefite are reduced by Manier	o' Componentian bountite		

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 6410 (Rev. 12/18) (Page 2 of 2)

<sup>\*\*</sup> If Workers' Compensation benefits are payable, member must apply for them. Accidental Disability Retirement Benefits are reduced by Workers' Compensation benefit \*Social Security Disclosure Requirement

Office of the New York State Comptroller New York State and Local Retirement System 110 State Street, Albany, New York 12244-0001

Received Date				

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

in blue or black ink				RS 6429 (Rev. 09/18)	
Patient Name: (First, Middle Initial, Last)		Date of Birth:		Social Security Number:	
Patient Address: (Including Street, City, State and Zip Code)					
<ol> <li>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), understand that:</li> <li>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 or the appropriate line in item 8(a). In the event the health information described below includes any of these types of information, and 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.</li> <li>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. understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. 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.</li> <li>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.</li> <li>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.</li> <li>THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN</li></ol>					
6. Name and address of health care provide	er(s) or en	tity(ies) to release this	s information:		
7. Name and address of person(s) or categ  New York State and Local Retirem					
films, referrals, consults, insurance	e records,		ou by other heal Include: (In		
(b) By initialing here I authorize				to discuss my health	
Initials			dual health care p		
information with my attorney or governmental agency listed here:  New York State and Local Retirement System  (Attorney/Firm Name or Government Agency Name)					
9. Reason for release of information:	riiii Naiii		· ·	on will evering at the completion of the	
At the request of individual     Other:		10.		on will expire at the completion of the nent application process:	
11. If not the patient, name of person signing	g form:	12.	Authority to sign	n on behalf of patient:	

Date

Signature of patient representative authorized by law

<sup>\*</sup>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.