Office of the New York State Comptroller
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

Received Date

Application for Police & Fire Retirement for Disability Incurred in Performance of Duty and ERS Members Covered Under Section 607-g and 89-v

RS 6442

(Rev. 11/22)

NYSLRS ID

Social Security Number [last 4 digits] XXX-XX-

Retirement System [check one]
Employees' Retirement System (ERS) ☐
Police and Fire' Retirement System (PFRS) ☐

Please return this application to the Retirement System in an envelope marked "Personal and Confidential Mail Drop 7-1"

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

INFORMATION ABOUT YOU

1. If applicable, check off the following benefit(s) that you are applying for:
☐ HIV (List occurrence(s) in Section 14 ☐ Heart Related ☐ TB or Hepatitis

2. Name: (First, Middle Initial, Last)		3. Date of Birth:
4. Address: (Including Street, City, State 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 No, Explain.

10. I am permanently disabled because of the following medical condition(s): (Use additional sheets if required)

11. I HAVE BEEN TREATED BY THE FOLLOWING 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:
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. DATES OF OCCURRENCES, WHERE THEY OCCURRED, AND WORKERS' COMPENSATION NUMBER(S) ASSIGNED: (Please describe occurrences in Section 14)

14. DESCRIPTION OF THE OCCURRENCE(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 occurrence(s), please provide names and contact information on an additional sheet of paper.

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

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.

Office of the New York State Comptroller

NYSLRS

New York State and Local Retirement System

110 State Street, Albany, New York 12244-0001

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

RS 6429

(Rev. 09/18)

Patient Name: (First, Middle Initial, Last)	Date of Birth:	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:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, 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:

7. Name and address of person(s) or category of person to whom this information will be sent:
New York State and Local Retirement System, Mail Drop 7-1, 110 State Street, Albany NY 12244

8. (a) Specific information to be release:

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, insurance records, and records sent to you by other health care providers.

☐ Other: _____
_____

Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____ to discuss my health
Initials — Name of individual health care provider

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: ☐ At the request of individual ☐ 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**.