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

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

RECEIVED

Application for Performance of Duty Disability Retirement

For Uniformed Personnel in the
NYS Department of Corrections,
and Security Hospital Treatment Assistants

RS 6047-A

(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. CHECK OFF THE FOLLOWING BENEFIT(S) THAT YOU ARE APPLYING FOR:
☐ Inmate related or HIV (List occurrence(s) in Section 15) ☐ Heart Related ☐ TB or Hepatitis

2. NAME	**3. SEX:** ☐ **M** ☐ **F**	**4. SOCIAL SECURITY NUMBER*** XXX-XX-
5. ADDRESS		**6. REGISTRATION NUMBER**
		7. DATE OF BIRTH / /
8. TELEPHONE NUMBERS: HOME ( ) **WORK ( ) CELL ( )**		**9. EMPLOYER**
10. PAYROLL TITLE		**11. LENGTH OF SERVICE** _____ Years _____Months

12. PAYROLL STATUS: On Payroll & Receiving Salary? ☐ Yes ☐ No If No, Explain.

13. FOR UNITED STATES TAX WITHHOLDING AND REPORTING PURPOSES (PLEASE CHECK ONE),
I AM A: ☐ **U.S. CITIZEN** ☐ **RESIDENT ALIEN** ☐ **NONRESIDENT ALIEN**

14. I AM PERMANENTLY DISABLED BECAUSE OF THE FOLLOWING MEDICAL CONDITION(S): (Use additional sheets if required)

15. DATES OF OCCURRENCES, WHERE THEY OCCURRED, AND WORKERS' COMPENSATION NUMBER(S) ASSIGNED**
(Please describe occurrence(s) in Section 18.)

16. I HAVE BEEN TREATED BY THE FOLLOWING DOCTORS: (Use additional sheets if required)

Primary Care Physician	Doctor	Doctor
Internal Med/Family Practitioner	Medical Speciality	Medical Speciality
Street	Street	Street
City, State and Zip Code	City, State and Zip Code	City, State and Zip Code
Doctor	Doctor	Doctor
Medical Speciality	Medical Speciality	Medical Speciality
Street	Street	Street
City, State and Zip Code	City, State and Zip Code	City, State and Zip Code

17. LIST HOSPITALIZATIONS, 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	

18. DESCRIPTION OF THE OCCURRENCE(S). ALSO DESCRIBE ANY OTHER OCCURRENCES THAT MAY BE RELATED TO YOUR CLAIMED DISABILITY. If your claimed disability is HIV, heart, tuberculosis or hepatitis related, please state why you believe your disability is job related. (Use additional sheets if required)

19. THE FOLLOWING PERSON(S) WITNESSED THE OCCURRENCE(S):

Witness Name	Witness Name	Witness Name
Date Witnessed	Date Witnessed	Date Witnessed
Witness Address	Witness Address	Witness Address
City, State and Zip Code	City, State and Zip Code	City, State and Zip Code

20. 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 contained on this form is true.

_____ _____

Applicant Name / Title (Please Print) Applicant Signature (Sign Name in Full) / Date

RELATIONSHIP TO MEMBER: ☐ Self ☐ Employer ☐ Other _____

(If applicant is not the member or employer, you must submit original documentation that authorizes you 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

** If Workers' Compensation benefits are payable, member must apply for them. Accidental Disability Retirement Benefits are reduced by Workers' Compensation benefits.

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.

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

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

RS 6429

(Rev. 5/15)

Patient Name	Date of Birth	Social Security Number XXX-XX-
Patient Address		

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 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 (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 released:

☐ 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 _____
Initials — Name of individual health care provider

to discuss my health 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:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ _____
Signature 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.**