ELECTED OFFICIALS' RETIREMENT PLAN
3010 E. Camelback Rd., Suite 200, Phoenix, Arizona 85016
(602)255-5575 FAX (602)296-2369 www.psprs.com

APPLICATION FOR DISABILITY RETIREMENT
(A.R.S. Section 38-806)

NAME: ____________________ DATE: __________

EMPLOYER: ____________________ POSITION: __________

SERVICE DATES: FROM ____________ THROUGH ____________

CURRENT ANNUAL SALARY RECEIVED: $ ____________

NAME OF MY DESIGNATED PHYSICIAN: ____________

ADDRESS OF MY DESIGNATED PHYSICIAN: ____________

TO: Board of Trustees

I hereby submit my application for a disability pension, subject to all the terms of the Arizona Elected Officials' Retirement Plan.

DATE OF DISABILITY: ____________

NATURE AND CAUSE OF DISABILITY: ____________

List of all doctors who attended or examined me during my disability and three years prior thereto:

#1	#2	#3
Name:	Name:	Name:
Address:	Address:	Address:
Phone:	Phone:	Phone:
Date: / /	Date: / /	Date: / /
Illness:	Illness:	Illness:

List of all hospitals or clinics where I have been treated or examined during my disability and three years prior thereto:

#1	#2	#3
Name:	Name:	Name:
Address:	Address:	Address:
Phone:	Phone:	Phone:
Date: / /	Date: / /	Date: / /
Illness:	Illness:	Illness:

(**NOTE:** Please complete 2nd page)

MEDICAL AUTHORIZATION

The information contained in this application is true, complete and correct to the best of my knowledge and belief. Furthermore, by this Medical Authorization or a reproduction hereof, I hereby authorize and request each physician and person in the medical or related fields, and each hospital, clinic, establishment and place rendering or having in the past rendered to me any medical or related service to allow the office of the board of trustees of the EORP, their authorized designee, and/or each physician appointed by them to have, examine and/or copy, any and all information, records, reports and x-rays, regarding my physical and/or mental condition and treatment therefore.

_____/_____/_____ ____________________ ____________________

DATE MEMBER'S SIGNATURE WITNESS SIGNATURE

MEMBER

Name: ___________________________ Date of birth: _____/_____/______ Social Security Number: _____-____-______

Address: ____ Home phone number: (______) _______-__________

____ Work phone number: (______) _______-__________

Email: ____ Cell phone number: (______) _______-__________

SPOUSE

Name: ___________________________ Date of Birth: _____/_____/______ Date of Marriage: _____/_____/______

Social Security Number: _______-_____-_______

DEPENDENT CHILDREN

NAME	DATE OF BIRTH	IS CHILD DISABLED?	Is child 18-22 and in school fulltime?
	/ /	YES NO	YES NO
	/ /	YES NO	YES NO
	/ /	YES NO	YES NO
	/ /	YES NO	YES NO
	/ /	YES NO	YES NO

NOTE: Please provide a copy of:

1. Your Birth Certificate
2. Your Marriage Certificate
3. Your Spouse's Birth Certificate
4. Your Dependent Children's Birth Certificates
5. If Divorced during period of employment:
    a. Photocopy of complete Divorce Decree, or
    b. Certified Copy of Plan-Approved Domestic Relations Order
6. Medical Documentation for Disabled Children. (If applicable)

(**NOTE:** Please complete 3rd page)

WAIVER OF CONFIDENTIALITY

The undersigned hereby consents, upon the advice of counsel, that all matters and issues relating to my physical or mental condition or medical history, including, without limitation, whether my physical or mental condition arises from any preexisting disability, may be discussed and considered by the board of trustees and/or Local Board in open public meeting, and I hereby waive any right to have my physical or mental condition or medical history discussed and evaluated by the board of trustees and/or Local Board in executive session only. As part of the aforesaid waiver, I further consent that the board of trustees and/or Local Board may discuss and consider all evidence touching upon my physical or mental condition or medical history in open public session, including without limitation, testimony or records concerning my physical or mental condition or medical history from physicians or other expert witnesses, the social security administration, the state industrial commission, or other sources or persons of any kind or description. I understand that neither the board of trustees nor the Local Board has any obligation to keep confidential any information about my physical or mental condition or medical history that is discussed, presented or considered during any public session of the board of trustees or Local Board, and I absolve the board of trustees and Local Board from any liability arising from disclosure of such information during public session.

By: ____
(Printed Name)

By: ____
(Member's Signature)

EMPLOYMENT CERTIFICATION

Date Application Received by board of trustees: _______/_______/_______

Member's Last Day on Employer Payroll: _______/_______/_______

By: ____
Signature

____
Title

TO BE COMPLETED BY board of trustees:
Based upon the medical evidence attached and pursuant to the Elected Officials' Retirement Plan statutes, the member named herein

☐ Qualifies for a disability pension pursuant to A.R.S. Section 38-806.

☐ Does not qualify for a disability pension.

DATE: _______/_______/_________

By: ____
BOARD OF TRUSTEES