PUBLIC SAFETY PERSONNEL RETIREMENT SYSTEM

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Phoenix, Arizona 85016-4416
(602) 255-5575 | www.psprs.com

FORM P5-EE
10/2024

FAX: (602) 296-2369
Email: *Approvedretdocs@psprs.com*

APPLICATION FOR DISABILITY RETIREMENT

(Completed by Employee)

PRINT INFORMATION:			
FULL NAME OF EMPLOYEE (FIRST, MIDDLE, LAST. SUFFIX)			**SSN**
ADDRESS *(Street) (Apt#) (City, state & Zip Code)*			**DATE OF BIRTH** *(MM/DD/YYYY)*
HOME PHONE #	**CELL PHONE #**	**WORK PHONE #**	**E-MAIL**

EMPLOYER: _____

TYPE OF DISABILITY (CHECK ONE): ☐ Accidental ☐ Ordinary ☐ Temporary ☐ Catastrophic

DATE OF DISABLING EVENT OR CONDITION DIAGNOSIS: _____

NATURE AND CAUSE OF DISABILITY: _____

List the physicians, hospitals and clinics who attended or examined your disability and three years prior to diagnosis. *For additional physicians, attach a supplemental page.*

COMPANY NAME	**COMPANY NAME**	**COMPANY NAME**
PHYSICIAN NAME	**PHYSICIAN NAME**	**PHYSICIAN NAME**
ADDRESS *(Street) (Apt#) (City, state & Zip Code)*	**ADDRESS** *(Street) (Apt#) (City, state & Zip Code)*	**ADDRESS** *(Street) (Apt#) (City, state & Zip Code)*
PHONE	**PHONE**	**PHONE**
ILLNESS (PROVIDE DETAILS)	**ILLNESS (PROVIDE DETAILS)**	**ILLNESS (PROVIDE DETAILS)**

For additional biological or legally adopted children, attach a supplemental page.

SPOUSE AND/OR BIOLOGICAL / LEGALLY ADOPTED CHILDREN		**PRINT NAME: (LAST, FIRST, MIDDLE)**	**DATE OF BIRTH** *(MM/DD/YYYY)*	**SOCIAL SECURITY NUMBER**	**DISABLED CHILD(REN)? YES OR NO**	**CHILD(REN) 18-22 YEARS IN SCHOOL FULLTIME? YES OR NO**
☐ Spouse	☐ Not applicable				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child	☐ Not applicable				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child	☐ Not applicable				☐ Yes ☐ No	☐ Yes ☐ No
☐ Child	☐ Not applicable				☐ Yes ☐ No	☐ Yes ☐ No

EMPLOYEE AUTHORIZATIONS:

INITIAL THE FOLLOWING - Authorizations are in effect from the date of this application to 120 days after first receipt of retirement benefits

1) I _____ 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 local board, the office of the Board of Trustees of the Public Safety Personnel Retirement System (PSPRS), 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.

2) I _____ authorize the local board, the office of the Board of Trustees and/or their authorized designee to procure from my employer(s) or from any other person, firm or corporation (including any governmental agency or department thereof) any and all information as directly related to leave(s) of absence without pay and/or application(s) for and/or receipt of Worker's Compensation Benefits. I expressly waive all provision of law forbidding any physician, person, firm or corporation (including any governmental agency or department thereof) from disclosing any knowledge or information which they have in their possession concerning leave(s) of absence without pay and/or Worker's Compensation.

3) I _____ understand that pursuant to A.R.S. § 38-847(H), the Board of Trustees may perform a review of the disability retirements to ensure that the employee and local board are in compliance with statutory requirements.

4) _____WAIVER OF CONFIDENTIALITY. I hereby consent, 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.

I hereby submit my application for a disability pension subject to all of the terms and conditions of the PSPRS. I attest that all information submitted is true, complete and correct to the best of my knowledge and belief. I understand that A.R.S. § 38-849(B) states: "A person who knowingly makes any false statement or who falsifies or permits to be falsified any record of the system with an intent to defraud the system is guilty of a class 5 felony."

_____ _____
EMPLOYEE SIGNATURE *DATE:*

Provide a copy of the applicable documents to your local board.

1. ☐ Birth certificate, Driver's License, or Passport for member
2. ☐ Recorded Marriage and birth certificate for spouse
3. ☐ Dependent child(ren) birth certificates
4. ☐ Medical documentation for disabled children
5. ☐ If divorced during period of employment: Divorce Decree, or Certified Domestic Relations Order

Retirees are eligible for health insurance benefits. Contact your employer and/or PSPRS for information.

LOCAL BOARD RECEIPT ACKNOWLEDGMENT-See A.R.S. § 38-847(D)(3):

_____ _____
RECEIVED STAMP, OR LOCAL BOARD REPRESENTATIVE SIGNATURE ***DATE:***