



City of Waterbury

Pension and Benefits Office
236 Grand Street
Room 222
Waterbury, CT 06702
Phone 203-574-6844 Fax 203-346-2685



Instructions

- All applicable sections must be completed. Questions regarding this application should be addressed to the above office.
- Part I – To be completed by employee with a signature by your Department Head.
- Part II – To be completed by employee but does not need to be seen by your Department.
- Complete the Authorization to Use and Disclose Health Information Form; which is attached to this application.
- Intentional misstatements or misrepresentations on this application could subject you to disciplinary action.

Application for Disability Retirement and Pension Benefits - PART I

Applicant Information

Full Name: _____ **Former Name:** _____
Last First M.I. if applicable

Address: _____
Street Address Apartment/Unit #

_____ *City State ZIP Code*

Home Phone: () _____ **Cell Phone:** () _____ **Social Sec. #** - -

Marital Status: _____ **Union:** _____ **Date of Birth:** _____

Date of Hire: _____ **Last Day Worked:** _____ **Termination Date:** _____

OFFICE USE ONLY	
VERIFIED BY	
_____	_____
_____	_____
_____	_____

Have you bought military service? YES NO If yes, how many months? _____

Have you purchased any yrs of service? YES NO If yes, how many years? _____

Have you had prior yrs. of credited service? YES NO If yes, how many years? _____

Nature of Claimed Disability (Please Check One):

____ Service Connected Disability ____ In the Line of Duty (Police or Fire Union Only)

____ Non-Service Connected Disability

Service Pension

____ I am also applying for a service based pension

Disclaimer and Signature

All Retirement Calculations are subject to the verification of the Pension and Benefits Office

I certify that my answers are true and complete to the best of my knowledge.

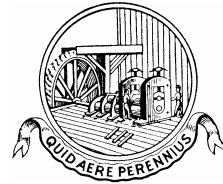
Signature: _____ Date: _____

Department Head
Signature and Title: _____

Please Print Name: _____

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Application for Disability Retirement and Pension Benefits - PART II

Applicant Information

Full Name: _____ Former Name: _____
Last First M.I. if applicable

Date of Claimed Disability: _____
MM/DD/YYYY

Date you first received medical aid for this condition and/or injury: _____
MM/DD/YYYY

Please provide a complete and detailed description of your claimed disability and the circumstances of its occurrence. Please be specific including the nature of your injury if applicable.

List all physicians who have been consulted for your claimed condition and/or injury:

Are you receiving, or have you applied for, workers' compensation benefits? Yes ___ No ___
Other than employment with the City of Waterbury, are you presently employed in any capacity?

Yes ___ No ___ Position and Employer _____

Are you presently disabled (as defined in the Retirement System Ordinance, as modified by any applicable collective bargaining agreement)? Yes ___ No ___

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge. I also understand that all Retirement Calculations are subject to the verification of the Pension and Benefits Office

Signature: _____ Date: _____

Please Print Name: _____

Office Use Only

Employee # _____ Next Board Meeting: _____ Proposed Benefit Date: _____

Received by: _____ Calculation done by: _____

PENSION AND RETIREMENT SYSTEM CITY OF WATERBURY

Authorization to Use and Disclose Health Information [Complies with requirements of HIPAA Privacy Rule]

Name of Participant: _____ Date of Birth: _____
MM/DD/YYYY

Union Membership: _____ Social Security No.: _____ - _____ - _____

I authorize any licensed physician, medical practitioner, nurse, pharmacist, hospital, or clinical medical facility who has any information as to the diagnosis, treatment, or prognosis of my physical or mental condition to disclose all health information maintained by that provider (**which may include HIV-related information and/or information relating to substance abuse treatment and/or mental health diagnoses and treatment**), and to communicate orally or in writing with the City of Waterbury Retirement Board concerning my medical history, treatment, diagnosis, prognosis, and any other information relating to any injury, condition or claim, in accordance with the following:

- 1. I authorize all providers to disclose the health information described above to the City of Waterbury Retirement Board at the following Address:**

City of Waterbury
Retirement Board
Pension and Benefits Office
236 Grand Street
Waterbury, CT 06702

- 2. The purpose for which the information will be used or disclosed is for processing my Application for Disability Retirement & Pension Benefits under the City of Waterbury Pension and Retirement System.**

- 3. Expiration:**

This Authorization will expire on the following date or upon the occurrence of the following event: _____ (If no date or occurrence is given, the Authorization will expire two years from the date of signature).

Please continue on the other side

I understand that, if the recipient of the information is not a health care provider or health plan covered by the federal HIPAA Privacy Rule, the information used or disclosed as described above may be re-disclosed by the recipient and no longer protected by the HIPAA Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, genetic information, HIV/AIDS-related information, and psychiatric/mental health information.

I understand that I may revoke this Authorization in writing at any time, except to the extent that the organization(s) or person(s) listed above has already taken action in reliance on this Authorization, by notifying the City of Waterbury's Pension and Benefits Department in writing.

I understand that because the purpose of these medical examinations is to provide health care information to the City of Waterbury Retirement Board in connection with my application for disability pension benefits under the City of Waterbury Pension and Retirement System, my health care provider may refuse to provide me with health care if I refuse to sign this Authorization.

By signing below, I acknowledge that I have read and understand this Authorization form.

Signature of Participant or Participant's
Personal Representative

Date

If signed by the Participant's Personal Representative, please print name and describe relationship to the Participant or other authority to act (guardian, conservator, etc.):

Name

Relationship to Participant

Check here if you would like a copy of the signed Authorization Form