

**FIREFIGHTERS' RETIREMENT PLAN  
CITY OF ST. LOUIS  
1114 Market Street – Suite 900  
St. Louis, MO 63101  
(314) 622-3560**

**APPLICATION FOR A DISABILITY BENEFIT**

APPROVED ( ) DENIED ( )  
DATE \_\_\_\_\_

NO. \_\_\_\_\_  
DATE \_\_\_\_\_

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**Application for a Disability Benefit**

( ) **LINE OF DUTY**  
**Any Occupation**

( ) **LINE OF DUTY**  
**Firefighter**

( ) **ORDINARY**  
**Any Occupation**

In accordance with the provisions of the law governing the operation of the Firefighters' Retirement Plan of St. Louis, I, \_\_\_\_\_ of \_\_\_\_\_  
Name Address  
\_\_\_\_\_, a participant in the Plan, hereby apply for a disability benefits because I am disabled from (mark one): ( ) engaging in any gainful employment in any occupation; or ( ) performance of duty as a firefighter.

I hereby authorize my physician to report directly on my condition to the physician or medical board designated by the Plan, and I hereby authorize the St. Louis Fire Department to release any and all medical information, reports of injury and sick time records to the Firefighters' Retirement Plan of St. Louis. I hereby consent to examination, upon request, by a physician or physicians designated by the Firefighters' Retirement Plan of St. Louis.

I request that my retirement benefit become effective on the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_. I was born on the \_\_\_\_\_ day of \_\_\_\_\_ (month, year).

I have completed \_\_\_\_\_ years of service for the St. Louis Fire Department creditable to me under the provisions of the Plan.



6. Place a check mark in appropriate box to show whether you are:
- (a) Confined in a medical institution other than a general hospital. Give type of institution.
  - (b) Patient in a general hospital.
  - (c) Confined in bed at home.
  - (d) Confined in a chair (including wheelchair).
  - (e) None of the above, but unable to go outside.
  - (f) Able to go outside but only with help of another person or device.
  - (g) Able to go outside without help.
  - (h) Required to wear a prosthetic appliance.
  - (i) Other condition(s). Explain
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7. Fill in the following blanks giving information about any medical treatment or examination that you have had. This information requested refers to your present disability. Please use supplemental pages if necessary to list all treating and examining physicians for the condition for which you are seeking disability benefits.

Name and address of doctor, hospital or agency	<u>Date of Medical</u> First examination	<u>Examination</u> Most recent examination

8. Do you agree to notify the Firefighters' Retirement Plan of the City of St. Louis promptly if your condition improved or if you are able to go back to work or accept any paid employment?  
 Yes \_\_\_\_\_ No \_\_\_\_\_

9. Do you authorize any physician, hospital, governmental agency or other organization to disclose to the Firefighters' Retirement Plan of the City of St. Louis any medical records or other information about your impairment(s)? Yes \_\_\_\_\_ No \_\_\_\_\_
10. Do you agree to notify the Firefighters' Retirement Plan of the City of St. Louis of any subsequent employment and to submit to the Firefighters' Retirement Plan of the City of St. Louis a copy of your annual federal income tax return? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Claimant:

\_\_\_\_\_

(Print Full Name)

Legal Signature

\_\_\_\_\_

10. Telephone No.: \_\_\_\_\_ (home)

\_\_\_\_\_ (cell)

11. State of Missouri )  
City of St. Louis )

On this \_\_\_\_\_ day of \_\_\_\_\_, 2013, before me personally appeared the above-named appellant, who being first duly sworn, stated that the facts set out in the foregoing request are true to the best of his/her knowledge and belief.

\_\_\_\_\_, Notary Public in and for the City of St. Louis,  
State of Missouri.

My Commission Expires:

\_\_\_\_\_