Employees' and Elected Officials' Retirement Systems
7 East Redwood Street, 13th Floor
Baltimore, Maryland 21202-3470
Phone: 443-984-3200 Fax: 443-853-3767
Member Self-Service Portal: bcers.org (Member Services)

DISMEMBERMENT DISABILITY APPLICATION

INSTRUCTIONS

- You must be an ERS class C or class D member.
- You must have had an on-the-job accident resulting in the loss of two body parts (hands, feet, and/or eyes) to apply.
- Complete all answers clearly and completely.
- Be specific. Do not write "all" or "none."
- If there is not enough room on the application, use an additional sheet to complete your answer.
- You must have the application notarized.

IMPORTANT NOTICE

- When you sign this application, you are certifying under penalty of perjury that it is **complete and true**.
- If your application is not complete and true, **you may lose your benefit and you may be prosecuted**.

RELEASES

- You must submit the attached releases before your application will be considered.
- You must sign a release allowing your doctors to discuss your medical history with the Retirement System. See Appendix 1, attached.
- You must sign a release allowing the Retirement System to discuss your medical history with your department, Key Risk, the Office of the Inspector General, and other agents of the City of Baltimore. See Appendix 2, attached.
- You must sign the attached release allowing Mercy Medical Systems to discuss your medical history with the Retirement System.

DOCTOR EXAMS AND RECORDS

- If you receive any new medical records, you must promptly submit them to the Retirement System before the hearing.
- You must have your doctor assess your disability and ability to do your job. See Form 25, attached. If you do not submit the Form 25, your application will not be considered.
- You must have a doctor chosen by the Retirement System assess your disability and ability to do your job.

HEARING

- Your application will be determined at a hearing.
- Your testimony will be under oath.
- You, the claimant, must prove that you have sustained any one of the losses specified in Baltimore City Code, Article 22 § 9(k)(5) or § 9.2(j)(5), that your disability was caused by an on-the-job accident, and that you were not willfully negligent.
- You have the right to have an attorney with you at the hearing.

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APPLICATION FOR DISMEMBERMENT DISABILITY RETIREMENT

OFFICE USE ONLY

Date Application Filed _____ Pension # _____

Creditable membership service on date of application: _____ Years _____ Months _ Days

Applicant advised of his/her eligibility to apply for Service Retirement _____ (Applicant Initial) Has applied? ❑ Yes ❑ No

Verified by Retirement Benefits Analyst _____

Application taken under advisement? ❑ Yes ❑ No

Reason

I hereby apply for **DISMEMBERMENT DISABILITY RETIREMENT** under Article 22 of the Baltimore City Code.

1. Full name of claimant _____
2. Last 4 of SSN _____ 3. Date of Birth _____
4. Home address _____

   _____
5. Phone: Work _____ Home _____
6. Marital status: ❑ Married ❑ Divorced ❑ Widowed ❑ Never married

   If married, name of spouse _____ Date of Birth _____
7. When did your employment with Baltimore City begin _____ end _____
8. Latest job classification _____
9. Department # and location _____
10. Most recent full-duty supervisor _____
11. What was your last full-duty job assignment in the employ of Baltimore City? _____
12. When did this job assignment begin _____ end _____
13. Was it a full-time job assignment? ❑ Yes ❑ No

    If "No," explain _____
14. When was the last day that you performed actual work for the City of Baltimore? _____

15. Is your incapacity the result of an accident which occurred while you were in the actual performance of duty?
❑ Yes ❑ No If "Yes," answer (a) through (d):

(a) Date and time the accident occurred _____

(b) Place of accident _____

(c) Describe the accident and how it happened _____

_____

(d) Names and addresses of witnesses to the accident _____

_____

16. Have you experienced one of the following (choose one):

❑ Loss* of one hand ❑ Loss* of one foot ❑ Loss of sight† of one eye

❑ Loss* of both hands ❑ Loss* of both feet ❑ Loss of sight† of both eyes

* Loss of hand or foot means dismemberment by severance at or above the wrist or ankle joint.

†Loss of sight means acuity of 20/200 or less with the use of correcting lenses and/or field of vision of 20 degrees or less.

17. Do you consent to release to the panel of Hearing Examiners all medical records pertaining to both off-duty and line-of-duty accidents or illnesses you may have suffered at any time in the past, in accordance with the provisions of Maryland Code, Health-General Article §§ 4-301 *et seq.* and Subtitle E of 45 CFR 160? ❑ Yes ❑ No

NOTICE: Your eligibility for Dismemberment Disability Retirement will be determined at a hearing to be conducted by a Hearing Examiner in accordance with Article 22 of the Baltimore City Code. It will be in the nature of an adversary proceeding with testimony taken under oath. You, the Claimant, have the burden of proving, by the preponderance of the evidence, that you have incurred a dismemberment, as the result of an accident while you were on duty, without willful negligence on your part, that meets the requirements of section 9(k) or section 9.2(j) of Article 22 of the Baltimore City Code, respectively.

18. **YOU HAVE THE RIGHT TO BE REPRESENTED BY COUNSEL OF YOUR CHOICE.** Will you be represented by counsel?
❑ Yes ❑ No If "Yes," give name, address and telephone number of your attorney:

_____

_____

_____

I do solemnly declare and affirm under the penalties of perjury that the contents of this application are true and correct to the best of my knowledge, information and belief.

_____ _____
SIGNATURE OF CLAIMANT DATE

OATH

STATE OF MARYLAND, COUNTY/CITY OF _____

I hereby certify that on this _____ day of _____, 20_____, personally appeared before me _____ and made oath in due form of law that the matters and facts stated in the foregoing document are true as therein set forth.

MY COMMISSION EXPIRES _____ _____
NOTARY PUBLIC [Seal]

APPENDIX 1: MEDICAL RECORDS DISCLOSURE AUTHORIZATION

_____
NAME OF HEALTH CARE PROVIDER OR MEDICAL FACILITY

THIS AUTHORIZATION IS FOR ANY RECORDS COVERING THE TIME PERIOD:

_____ to _____

I, the undersigned, for the purpose of processing my disability application, hereby authorize all medical sources, including, but not limited to, the above-named health care provider/medical facility, any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf, to disclose any or all of my protected health information, including, but not limited to, **any or all of my patient file, any or all medical records, radiology films/imaging**, and any or all protected health information, patient file, medical records, radiology films/imaging received from other health care providers to the Employees' and Elected Officials' Retirement Systems of the City of Baltimore ("Retirement Systems"). I understand that this protected health information may contain information pertaining to psychiatric, drug, alcohol, and HIV/AIDS diagnosis and treatment. I understand that the information disclosed pursuant to this authorization will no longer be protected by the Health Insurance Portability and Accountability Act. I understand that the health care provider/medical facility does not condition any treatment that I am otherwise entitled to receive on my signing this authorization. I understand that this authorization, except for action already taken, may be canceled by me at any time in writing to the Retirement Systems. I understand that my Application for Non-Line-of-Duty Disability Retirement will cease to be processed should I cancel this authorization.

THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF MY SIGNATURE BELOW.

_____ _____
SIGNATURE OF CLAIMANT DATE

_____
PRINTED NAME OF CLAIMANT

_____ _____
DATE OF BIRTH OF CLAIMANT SOCIAL SECURITY NO. OF CLAIMANT

If the Claimant is not able to consent to the release of the information:

_____ _____
SIGNATURE OF PERSON AUTHORIZED TO GIVE CONSENT DATE

_____ _____
PRINTED NAME AUTHORITY

APPENDIX 2: MEDICAL AND EMPLOYMENT RECORDS DISCLOSURE AUTHORIZATION

I, the undersigned, for the purpose of processing my disability application, hereby authorize the Employees' Retirement System ("Retirement System") to disclose any information received by the Retirement System pursuant to Appendix 1: Medical Records Disclosure Authorization, Form 25, Independent Medical Exams, Functional Capacity Exams, and the decision of the hearing examiner to my lawyer, the hearing examiner, the City of Baltimore and its agents and representatives, including, but not limited to, any department of the City of Baltimore, Key Risk (or any successor third-party Workers' Compensation administrator of the City of Baltimore), and the Office of the Inspector General, and any relevant law enforcement agency.

I authorize the City of Baltimore and its agents and representatives, including, but not limited to, any department of the City of Baltimore, Key Risk, and the Office of the Inspector General to disclose to the Retirement System any and all information in connection with the Retirement System's determination of my disability, including, but not limited to, medical records, personnel records, disciplinary records, and physical fitness exams. I hereby designate the Retirement System as my designee to receive that personnel information.

I authorize any employer with which I have submitted an application for employment after the date of the disability listed in this application for Dismemberment Disability Retirement to disclose to the Retirement System personnel records and medical records relating to my employment, including, but not limited to, my completed application, a description of the duties of the position for which I applied, statements of medical history completed as part of the application process, and physical exam or fitness test reports. I hereby designate the Retirement System as my designee to receive that personnel information. I authorize the Retirement System to disclose to any such employer any and all information described in this Medical and Employment Records Disclosure Authorization.

I understand that if judicial review of the decision of the hearing examiner is sought by me or the Retirement System, all of the information submitted into the record at the disability hearing, including, but not limited to, information received pursuant to this and any other authorization signed by me, as well as the decision of the hearing examiner, must be disclosed to the courts and any individuals involved in the judicial and appeal process, and therefore may be a matter of public record pursuant to judicial procedure. I authorize such disclosure.

SIGNATURE OF CLAIMANT

DATE

PRINTED NAME OF CLAIMANT

DATE OF BIRTH OF CLAIMANT

SOCIAL SECURITY NUMBER OF CLAIMANT

If the Claimant is not able to consent to the release of this information:

SIGNATURE OF PERSON
AUTHORIZED TO GIVE CONSENT

PRINTED NAME

AUTHORITY

Mercy
HEALTH SERVICES

Authorization for Disclosure of Protected Health Information (PHI)

Specific Provider or Medical Facility *(List all requested providers and facilities)*

Patient Last Name	**Patient First Name**	**Patient Middle Initial**
Social Security Number	**Date of Birth**	**Medical Record Number**
Street Address	**City**	**State/Zip Code**
Home Phone Number	**Work Phone Number**	**Mobile Phone Number**

I, the undersigned, hereby authorize the above named provider or medical facility to disclose in writing to the individual, entity, facility, or company named below my PHI contained in my medical record. I further authorize the above named provider or medical facility to disclose my PHI electronically and/or discuss my PHI verbally with the individual, entity, facility, or company named below. I hereby authorize the disclosed PHI to include (check ***ALL*** that apply):

	Bills		Nurse's Notes
	Claims		Operative Reports
	EKG/Catheterization Reports		Physician Orders
	Emergency Room Records		Progress Notes
	Hospital Discharge Summary		Radiology Films/Imaging
	History and Physical		Radiology Reports
	Laboratory Reports		ANY AND ALL RECORDS

Please release records covering the time period
(MM/DD/YYYY to MM/DD/YYYY): _____ to _____

Information to be disclosed to:
(Name and address of the individual, entity, facility, or company to receive my PHI) _____

Purpose of disclosure: _____

The PHI provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol and substance abuse, communicable diseases (including (HIV/AIDS) and/or genetic marker information.
I understand and agree to the following:

- Mercy Health Services does not condition health care treatment I am otherwise entitled to on whether I sign this authorization.
- I understand that the medical records to be accessed may contain medical information pertaining to psychiatric, drug, and/or alcohol, HIV/AIDS diagnosis and treatment.
- This authorization will expire one (1) year after the date of my signature below unless a shorter time period is stated here _____. (Must be a time period or date, not an event or condition).
- Information used or accessed under this authorization may be re-disclosed by the recipient and no longer protected by federal law but may be protected under Maryland law.
- I am free to revoke this authorization at any time by submitting a written request to the entity/provider disclosing the PHI. Any uses or disclosure of my PHI prior to receipt of the revocation cannot be reversed and will not be covered by the revocation.

Signature of Patient (or Legally Appointed Representative) _____ **Date** _____ **Printed name of Legally Appointed Representative** (if applicable) _____

Documentation establishing authority of Legally Appointed Representative
(Duly appointed Personal Representative, Health Care Power of Attorney, Advanced Directive, Parent of Minor Child, etc.)

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ACKNOWLEDGEMENT
REEMPLOYMENT AFTER RETIREMENT

I understand that if I am reemployed by the City of Baltimore, my retirement benefits will be terminated. I will be required to repay any and all retirement benefits received while reemployed, in accordance with Baltimore City Code, Article 22, sections 9(n) and 9.2(l). If I return to work as a contractual employee, I understand that:

- I am subject to an earnings limitation in accordance with City policy.
- The term of my contract must not exceed 1 year and 1200 paid hours per year.
- There must be a minimum of 90 calendar days between my last day on City payroll and the start date of my contract.

See Administrative Manual 212-1. I agree to notify the Board of Trustees of the Employees' and Elected Officials' Retirement Systems if I return to City employment.

_____ _____
Signature of Applicant Date

_____
Name of Applicant

State of Maryland
City of Baltimore

On this _____ day of _____, _____, before me, the undersigned officer, personally appeared _____, known to me or satisfactorily proven to be the person whose name is subscribed to within the instrument and acknowledged that he/she executed the same for the purposes therein contained.

In witness hereof I hereunto set my hand and official seal.

_____
Signature [Seal]

_____
Date

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ACKNOWLEDGMENT
WORKERS' COMPENSATION OFFSET

I understand that **my disability benefit will be reduced** to offset the full amount of any past **workers' compensation award made within the 5 years** previous to the date of the accident or the date of the award, if the workers' compensation award is based on the **same disability** as my disability retirement from the Employees' and Elected Officials' Retirement Systems, as provided by the Baltimore City Code, Article 22, sections 9(o-4), 9.2(o), and 22(h). I understand that if I receive a workers' compensation award for the same disability as my disability retirement, my workers' compensation award may be offset.

_____ _____
Signature of Applicant Date

_____
Name of Applicant

State of Maryland
City of Baltimore

On this _____ day of _____, _____, before me, the undersigned officer, personally appeared _____, known to me or satisfactorily proven to be the person whose name is subscribed to within the instrument and acknowledged that he/she executed the same for the purposes therein contained.

In witness hereof I hereunto set my hand and official seal.

_____
Signature [Seal]

_____
Date

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ACKNOWLEDGMENT
ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

I understand that I am responsible for having **my doctor** complete the **Attending Physician's Statement of Disability**. I agree to return this document to the office of the Employees' and Elected Officials' Retirement Systems within **30 days** of my signature below. I understand that **if I do not return this document, my application for disability will not be considered**.

_____ _____
Signature of Applicant Date

_____
Name of Applicant

State of Maryland
City of Baltimore

On this _____ day of _____, _____, before me, the undersigned officer, personally appeared _____, known to me or satisfactorily proven to be the person whose name is subscribed to within the instrument and acknowledged that he/she executed the same for the purposes therein contained.

In witness hereof I hereunto set my hand and official seal.

_____
Signature [Seal]

_____
Date

FORM 25

CLAIMANT NAME _____ SSN _____

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

TO: Panel of Hearing Examiners
Retirement Systems of the City of Baltimore

FROM: _____ M.D.
ATTENDING PHYSICIAN

_____	_____	_____
Name of Patient	Pension No.	Social Security No.

REQUEST TO PHYSICIAN: The purpose of this report is to assist in making a disability determination. Please include sufficient details of history, physical and diagnostic findings, clinical course, therapy, and response to help in determining the severity and duration of the disability. If you wish, you may provide this information to us in narrative form.

1. *HISTORY*:

   (a) When did symptoms first appear or accident happen?

   Month_____ Day_____ 20____

   (b) When did the patient cease work due to the disability?

   Month_____ Day _____ 20____

   (c) Names and addresses of other consulting physicians (attach additional sheet if necessary)

   _____

   _____

   _____

2. *DIAGNOSIS*: (Including any complications)

	PRIMARY	*SECONDARY*
(a)	_____	_____
(b)	_____	_____
(c)	_____	_____

3. *OBJECTIVE DATA*: Patient has experienced the following physical losses:

❑	Loss* of one hand	❑	Loss* of one foot
❑	Loss* of both hands	❑	Loss* of both feet
❑	Loss of sight† of both eyes	❑	Loss of sight† of one eye

* "Loss of hand" or "loss of foot" means dismemberment by severance at or above the wrist or ankle joint.

† "Loss of sight" means central visual acuity of 20/200 or less in one eye (or the better eye) with the use of correcting lenses or, if greater than 20/200, limitation in the field of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees.

4. *DATE OF LOSS.* When did the patient sustain the loss, whether the final cause was accidental or via surgical or other medical intervention?

Month _____ Day _____ 20_____

_____	_____	_____	_____
Date	Name of Attending Physician (Print) &	Degree	Telephone

_____	_____
Street Address	City, State & Zip Code

_____
Signature