CLAIMANT NAME _____ **SSN** _____]

THE CITY OF BALTIMORE
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)

LINE-OF-DUTY DISABILITY APPLICATION

INSTRUCTIONS

- You must apply within five years of an on-the-job accident.
- 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 Systems 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 Systems 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 Systems 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 are permanently and totally disabled from the duties of your job classification, that your disability was caused by an on-the-job accident, and that you were not willfully negligent.
- If you are an ERS Class C or D member, you must also prove that the incapacity resulting from the accident caused at least 50% anatomical loss of any one or 25% loss of any two body parts specified in Baltimore City Code, Article 22 § 9(j)(5) or § 9.2(i)(5).
- You have the right to have an attorney with you at the hearing.

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APPLICATION FOR LINE-OF-DUTY DISABILITY RETIREMENT

CHECK ONE: ❑ Employees' Retirement System of the City of Baltimore
❑ Class C ❑ Class D
❑ Elected Officials' Retirement System of the City of Baltimore

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 **LINE-OF-DUTY DISABILITY RETIREMENT** under Article 22 of the Baltimore City Code.

1. Full name of claimant _____
2. Social Security Number _____ 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. What were the principal duties of this job assignment? _____

_____

_____

15. Do you have a disability that prevents you from further performance of the duties of your job classification? ❑ Yes ❑ No

    If "Yes," explain _____

    On what date did you become totally and permanently incapacitated? _____

16. Which of these duties are you now incapable of performing due to your disability? Be specific; **do not say "none" or "all."**

    _____

    _____

17. Which of these duties are you still able to perform? Be specific; **do not say "none" or "all."** _____

    _____

    _____

18. When was the last day that you performed actual work for the City of Baltimore? _____

19. Since you began working for the City of Baltimore, have you ever held any other employment? ❑ Yes ❑ No

    If "Yes," answer (a) through (c):

    (a) Name, Address and Telephone number of Employer _____

    _____

    (b) Hours of work _____

    (c) Job duties _____

20. Do you presently hold any other employment? ❑ Yes ❑ No If "Yes," answer (a) through (c):

    (a) Name, Address and Telephone number of Employer _____

    _____

    (b) Hours of work _____

    (c) Job duties _____

21. What is the cause of your disability? (Name of injury or disease as diagnosed by your doctor) _____

    _____

    _____

22. List the names and addresses of all doctors or other health providers who have treated you for this condition and dates of treatment. Attach additional sheets as necessary. _____

    _____

    _____

23. If you were ever hospitalized for this condition, list the name of each hospital, dates hospitalized, and if known, your patient identification number. Attach additional sheets as necessary. _____

    _____

24. 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 _____

_____

25. Have you, at any time before or after this disabling condition, had any injury, illness, disease or other problem that affects your ability to perform the duties of your job classification? ❑ Yes ❑ No If "Yes," list by date, doctor and hospital.

PROBLEM	DATE	NAME OF DOCTOR	NAME OF HOSPITAL

26. 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 Line-of-Duty 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 are permanently and totally disabled from the further performance of the duties of your job classification, and that your disability is the result of an accident while you were on duty, at a definite time and place, without willful negligence on your part. If you are a Class C or Class D member of the Retirement System, you must also prove that the incapacity resulting from the accident meets the requirements of section 9(j)(5) or section 9.2(i)(5) of Article 22 of the Baltimore City Code, respectively, relating to the degree of qualifying impairments.

27. **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 Retirement Systems to disclose any information received by the Employees' and Elected Officials' Retirement Systems ("Retirement Systems") 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 Systems any and all information in connection with the Retirement Systems' determination of my disability, including, but not limited to, medical records, personnel records, disciplinary records, and physical fitness exams. I hereby designate the Retirement Systems 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 Line-of-Duty Disability Retirement to disclose to the Retirement Systems 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 Systems as my designee to receive that personnel information. I authorize the Retirement Systems 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 Systems, 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

CLAIMANT NAME _____ **SSN** _____]

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.)

F056813 (12/10)

Revised 9/2016

CLAIMANT NAME _____ **SSN** _____]

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7 East Redwood Street, 13th Floor Baltimore, Maryland 21202-3470
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Member Self-Service Portal: bcers.org (Member Services)

Acknowledgment
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

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) Date patient ceased work because of disability. Month_____ Day _____ 20____
   (c) Has patient ever had same or similar condition? Yes_____ No_____(If yes, state when and describe)
   _____
   _____
   (d) Names and addresses of other consulting physicians (attach additional sheet if necessary)_____
   _____

2. *DIAGNOSIS*: (Including any complications)

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

   (1) Subjective Symptoms or Patient's complaints: _____
   _____

3. *OBJECTIVE DATA*: (Including physical findings, laboratory data, EKGs, X-rays, or any other special tests.)
   (a) _____
   (b) _____
   (c) _____

4. *DATES OF TREATMENT*:
   (a) Date you first examined Month_____ Day _____ 20____
   (b) Date of last visit Month_____ Day _____ 20____
   (c) Frequency of visit Weekly_____ Monthly _____Other (*specify*)_____

5. *NATURE OF TREATMENT AND RESPONSE:* (If any surgery, please enclose operative report)

_____

_____

6. *PRESENT CONDITION AND PROGNOSIS*:

(a) Is this patient physically incapacitated? Yes_____ No_____

If so, why?_____

(b) Is the patient mentally incapacitated? Yes_____ No_____

If so, why?_____

(c) Is such incapacity likely to be permanent? Yes_____ No_____

If so, why?_____

7. *EFFECT OF PHYSICAL OR MENTAL IMPAIRMENT ON DUTIES OF JOB:*

Please describe in detail the patient's physical or mental limitations

_____

_____

*Percent of Disability*_____%

8. *CARDIAC:* (If applicable)

(a) Functional capacity _____ Class 1 (No limitation) _____ Class 2 (Slight limitation)
(American Heart Ass'n) _____ Class 3 (Marked limitation) _____ Class 4 (Complete limitation)

(b) Blood Pressure _____ _____ _____
Systolic Diastolic Date Recorded

9. *ANATOMICAL LOSSES OF USE CAUSED BY ACCIDENTS:* (If applicable) Please indicate the total percentage of anatomical loss (A.L.) and of this percentage, preexisting loss, if any (P.E.L.) of use of any of the following functions or body parts caused by an accident and the date of the accident (D/A) which caused the loss:

	% of A.L.	% of P.E.L	D/A		% of A.L.	% of P.E.L	D/A
1. Speech	_____	_____	_____	6.Central Nervous System	_____	_____	_____
2. Sight	_____	_____	_____	7. Arm	_____	_____	_____
3. Hearing	_____	_____	_____	8. Leg	_____	_____	_____
4. Neck	_____	_____	_____	9. Shoulder	_____	_____	_____
5. Back	_____	_____	_____	10. Vital Body Organ	_____	_____	_____

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

_____ _____
Street City, State & Zip Code

_____
Signature