BOARD OF TRUSTEES OF THE CHAMPAIGN POLICE PENSION FUND

Application for Disability Pension Benefits

Application must be completed in its entirety, dated, signed by Applicant, and notarized. This Application must be filed with the Pension Board in order to initiate a claim for disability benefits.

1. Name of Applicant: _____
2. Address: _____
3. Telephone: _____
4. Social Security Number: _____
5. Date of Birth: _____
6. Current salary: $_____ Salary on date of disability: $_____
7. Date of probationary appointment: _____
8. Date of regular appointment **and** current rank: _____
9. Identify the type of pension(s) Applicant is applying for (check as may be applicable):

   ( ) "Line of Duty" (40 ILCS 5/3-114.1)

   ( ) "Not on Duty" (40 ILCS 5/3-114.2)

   State whether physical or mental.

   ( ) "Heart Attack or Stroke Suffered in Performance of Duty" (40 ILCS 5/3-114.3)

   ( ) "Occupational Disease" (40 ILCS 5/3-114.6)

10. Date of removal from payroll: _____
11. Date(s) of any (all) sickness(es), accident(s), or injury(ies) (referred to as the "*event(s)*" which may have caused or contributed to the stated disability):_____

    _____

    _____

12. Date last worked full service for the Department: _____
13. Dates you worked for the Department on "light duty":_____

DEFINITIONS

The following definitions shall apply to the use of the term or word as set forth in the "Interrogatories" and "Request for Production":

The term "documents/documentation" as related herein, is used in its broadest sense and shall include, but not be limited to the following: medical records, reports of examination or treatment, records, writings, opinions, test results, x-rays, MRI's, correspondences, e-mails, memos, transcripts, recordings, videos, pictures, handwritten notes, records of communications, depositions, statements, affidavits, reports of incident, sickness(es), accident(s) and/or injury(ies), any and all other tangible evidence, etc.

The word "*event(s)*" as used herein, pertains to the specific date(s) of the occurrence(s)/incident(s) which forms the basis of your Application, i.e., when the specific sickness(es), accident(s), or injury(ies) occurred.

"Your condition" relates to the sickness(es), accident(s), or injury(ies) which has (have) been claimed in support of your Application for Disability Pension Benefits.

"Healthcare providers" as related herein, is used in its broadest sense, and shall include, but not be limited to the following: hospitals, clinics, physicians, psychiatrists, psychologists, sociologist, nurses, practitioners, physician's assistant, dentist, chiropractors, laboratory technicians, physical therapists, pharmacists and any other healthcare professional(s) or entities.

"Conversations/Communications" as related herein, is used in its broadest sense, and shall include, but not be limited to the following: e-mails, correspondences, memos, transcriptions, recordings, electronic communications, etc.

INTERROGATORIES

14. Provide the names, addresses and telephone numbers of all person(s) who witnessed the *event*(s).

_____

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15. Describe, in detail, how the sickness(es), accident(s) or injury(ies) was (were) caused (identify the location[s], date[s] and time[s]).

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16. As the result of the *event* in question, describe fully the sickness(es), accident(s) or injury(ies) (i.e., physical, or mental) of which you are complaining, and fully describe the parts of the body involved or affected.

(a) Prior to the *event* in question, state whether you had any pre-existing history of any sickness(es), accident(s), or injury(ies), respecting question #16 above, for which you are claiming a disability herein. Your answer should include any history, whether or not you received medical treatment for the same.

17. Identify when, how and to whom the sickness(es), accident(s), or injury(ies) was (were) reported.

18. State whether you were on shift duty the day of the *event(s)* and, if so, provide the times of your shift and the nature of your duties.

19. Provide your shift duty dates, vacation, sick and day(s) off, the week before the *event*(s), the week of the *event(s)*, and the week after the *event(s)*.

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20. Provide the names, addresses and telephone numbers of all persons, firms, corporations, or entities, other than this Department, who employed you commencing with five (5) years prior to the date of your hire by the Department through and inclusive of the date hereof.

_____

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_____

21. State whether you know or have been advised that any individual or entity may have any documentation or tangible evidence concerning the *event(s)* or sickness(es), accident(s) or injury(ies) in question. If the answer to this interrogatory is affirmative, please identify fully the name of said individual or entity, his, her or its address, telephone number and the precise nature and description of the documentation or tangible evidence.

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22. State the first date that you received medical treatment after the *event*(s) stated above, which has been provided in support of your Application. Provide the date(s) of treatment and the name of the medical provider.

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23. Provide the names, addresses and telephone numbers of all healthcare providers, who have treated and/or examined you respecting your sickness(es), accident(s) or injury(ies) in question. Provide the dates of any such treatment and/or examination. See definition of "healthcare providers".

PLEASE ATTACH A TYPEWRITTEN LIST OF THE ABOVE NAMES, ADDRESSES, TELEPHONE NUMBERS AND DATES OF SERVICE.

24. State whether you have been released from medical care for the sickness(es), accident(s) or injury(ies) for which you now claim a disability. If so, when, and state who released you.

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25. State whether you continue to receive treatment for your sickness(es), accident(s) or injury(ies). If the answer is "yes", state from whom you are receiving treatment. Also state the type of treatment and how often you receive treatment.

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26. State whether anyone has ever told you that your condition is "treatable". If so, identify who stated the same. Also, state the treatment required.

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27. State whether anyone has ever told you that your condition is "permanent". If so, identify who stated the same.

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28. State whether you returned to work after the sickness(es), accident(s) or injury(ies) in question. If so, when and for how long?

29. State whether you have discussed, inquired, or made application for other employment (other than the Champaign Police Department) with any other individual, corporation or entity, at the time of the *event(s)* in question and through and inclusive of the date hereof. If so, provide the name of the person, corporation or entity and full contact information, respecting the same.

30. State whether you received any pre-employment physicals, including psychological testing, as a condition of your hire as a police officer for the Department. If so, please provide the name of the physician and the date of your exam.

31. Please state if annual physicals are required by the Department..

32. Prior to the *event*(s) in question, please state the last time that you received a physical. State the name of the physician and the contact information.

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33. Provide a full list of any and all sickness(es), accident(s) or injury(ies) incurred or sustained by you for which you may have received any medical treatment and/or examination for twenty (20) years prior to the event(s) which you are claiming in support of your Application.

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34. Provide the names, addresses and telephone numbers of any and all medical providers who have treated and/or examined you over the past twenty (20) years, from the date hereof, for any reason, including but not limited to: sickness(es), accident(s) or injury(ies) or any other physical or mental condition and/or routine physicals. See definition of "healthcare providers".

PLEASE ATTACH A TYPEWRITTEN LIST OF THE ABOVE NAMES, ADDRESSES, TELEPHONE NUMBERS AND DATES OF SERVICE.

35. Names, addresses and telephone numbers of all persons, firms, entities, or corporations against who or which a claim has been made in the past, is currently pending, or shall be made in the future, as the result of the "*event(s)*" (worker's compensation, etc.).

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36. State whether you are receiving benefits and/or have ever received benefits under the Workers' Compensation Act, the Workers' Occupational Diseases Act, or the Public Employees Disability Act. If so, identify the name of the "Application for Adjustment of Claim", the number, and what benefits were received, are being received, or will be received:

_____

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37. State whether you have ever (in the past) filed a claim for any sickness(es), accident(s) or injury(ies) (other than the claim which is the subject matter of your application). If so, please provide full details respecting the same.

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REQUEST FOR PRODUCTION

1. Please provide copies of any and all medical reports and other documentation, including those from any medical provider relating to the *event(s)* in question and your claim for disability as represented in this Application.

2. Please provide copies of any and all reports or documentation relating to the sickness(es) accident(s) or injury(ies) in questions, either initiated by you or received by you, to or from any individual or entity including, but not limited to, copies of the reports of injury and management reports filed with your employer.

3. Please provide copies of any documentation relating to or referring the *event(s)* in question, the manner in which it occurred, and/or the sickness(es), accident(s) or injury(ies) complained of.

4. Please provide any and all medical reports and other documentation as identified in paragraphs 1 through 3 above, pertaining to any medical treatment/examination including, physicals or other health care.

5. If you are alleging the *event(s)* was (were) the result of the performance of an "act of duty" or any activity while on duty with the Department and/or you are requesting a "line of duty" disability pension pursuant to 40 ILCS 5/3-114.1, please provide any and all documents initiated by you, or any other individual or entity, the same which may in any manner relate to such activity.

The attached "Request and Authorization to Copy Health Information" must be completed and returned with and as a part of this Application.

If insufficient space is provided to answer any of these questions, please continue your answer on a separate sheet of paper and attach it as part of this Application, referring to the question number.

The Applicant acknowledges that he/she has an obligation to hereinafter supplement the information requested in this Application and Request for Production, as may be required. The Applicant agrees that he/she shall supplement the above as may be required and without further request from any party or entity to comply with the same.

The Applicant acknowledges that pursuant to this Application, he/she may be required to respond to additional interrogatories and/or request for production from the Board. By his/her signature hereunder, Applicant agrees that he/she shall comply as may be required.

Under penalties of perjury, the undersigned certifies that the statements set forth in this Application and all other documents, data, and information submitted in support hereof, are true, correct, and complete.

Dated: _____ _____*
Date Signature of Applicant

Subscribed and sworn to before me this _____ day of _____, 20_____.

_____
Notary Public

*In the event this Application has been prepared and/or signed by a person other than the police officer, said individual shall state his or her relationship and/or capacity of representation and the reason thereof.

_____

_____

(This Application shall not be legally effective until such time as it is filed with the Board.)

Filed with the Board on this _____ day of _____, 20_____ at _____.
(Time)

_____
Signature of Board

PLEASE TYPE

(In reply to Item #23)

Names, addresses and telephone numbers of all healthcare providers, who have treated and/or examined you respecting your sickness(es), accident(s) or injury(ies) in question. Provide the dates of any such treatment and/or examination. See definition of "healthcare providers".

PLEASE TYPE

(In reply to Item #34)

Names, addresses and telephone numbers of any and all medical providers who have treated and/or examined you over the past twenty (20) years, from the date hereof, for any reason, including but not limited to: sickness(es), accident(s) or injury(ies) or any other physical or mental condition and/or routine physicals. See definition of "healthcare providers".

REQUEST AND AUTHORIZATION TO COPY HEALTH INFORMATION

I authorize _____ to release my health information as described below, to the named recipient for the purpose as set forth in this Authorization.

SECTION I: PATIENT INFORMATION

Patient Name (last, first, middle Initial):			
Birthdate:		IMedical Record Number (if applicable):	
Address:			
City:	IState	IZip:	IPhone:

SECTION II: INFORMATION REQUESTED

I authorize the use or disclosure of the following health information during the term of this Authorization. Any and all medical records and information, including but not limited to the following (medical records and information shall be interpreted in its broadest sense):

- Clinic Visit Notes
- Treatment Records
- Physical Examinations
- Emergency Room Reports
- Surgical (Operative Report, Path Report)
- Hospitalizations (H & P, Consult, Test, Surgical, Discharge Summary)
- X-ray Films
- Test Results (Specify: Lab, X-ray, EKG, etc.)
- Complete Medical Records
- Billing Records
- Therapy Notes
- Independent Medical Examinations

For the following dates of treatment (for example: specific date 01/25/17; or range of dates Jan.-July 2016; or all dates of service): **ANY AND ALL DATES OF SERVICE**

SECTION III: RECIPIENT AND PURPOSE:

If this information is not being delivered to me, then deliver my health information to (for example: insurance company, school, attorney):

Name of Person: Atty. Charles H. Atwell – Charles@atwellandatwelllaw.com	Phone Number: 630-892-4341
Name of Organization: Atwell & Atwell Law Offices on behalf of the City of Champaign Police Pension Fund Board	
Street Address: 70 S. Constitution Drive, Suite 100	
City, State, Zip: Aurora, Illinois 60506	
The purpose of the disclosure is (for example: worker's compensation claim review; disability; request of patient): Claim filed with the Board of Trustees of the City of Champaign Police Pension Fund for disability pension benefits.	

PLEASE READ THIS PAGE CAREFULLY

SECTION IV: SPECIFIC CONSENT:

By checking any of the boxes below, I am specifically authorizing to disclose the category of confidential information indicated next to the box, if applicable to this Authorization.

- ☐ Information about a Mental Illness (psychological or psychiatric testing, evaluations, treatment or examination) or Developmental Disability**
- ☐ Psychotherapy Notes (which are not part of the official medical record)
- ☐ Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ☐ Information about Communicable Diseases
- ☐ Information about Sexually Transmitted Disease(s)
- ☐ Information about Substance (i.e., alcohol or drug) Abuse
- ☐ Information about Abuse of an Adult with a Disability
- ☐ Information about Sexual Assault
- ☐ Information about Child Abuse and Neglect
- ☐ Information about Genetic Testing
- ☐ Information about Infertility/IVF/Artificial Insemination

SECTION V: EFFECTIVE DATE OF AUTHORIZATION:

This Authorization will remain in effect under the following conditions (**check one preference**):

- ☐ From the date of this Authorization until the following date: _____.
- ☐ Until the purpose if fulfilled.
- ☐ Until the following event occurs: _____
- ☐ Other (e.g. no expiration): _____

Note: The term for mental health records must be stated – you may not use "no expiration". If no termination event is filled in, then this Authorization will expire 90 days after the date signed below.

I understand I may revoke this Authorization at any time provided I do so, in writing, to the Board of Trustees of the Champaign Police Pension Fund, or its attorney, except to the extent the records have already been released.

I understand authorizing the disclosure of health information is voluntary. I can refuse to sign this Authorization. I understand if the person or entity receiving the information is not a health care provider or health plan covered by Federal HIPAA privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I have read and understand this Authorization. A photocopy of this authorization shall be as valid and effective as the original.

_____ _____

Signature of Patient or Personal Representative* Date

_____ _____

Name of Personal Representative• (if applicable) Relationship to Patient

*The Personal Representative is the patient's decision maker. It can be the parent if the patient is a minor, legal guardian, health care surrogate, or other person.

****A witness signature Is required for the release of information about a mental illness or developmental disability.**

Signature of Witness:_____ Date: _____

Name of Witness: _____

(Please Print Name)