

Application for Disability Retirement

Last Name:	First Name:	Middle Initial:
<i>*Birth certificate or proof of birth is required</i>		
Date of Birth:	Social Security #:	
Address:	City:	State: Zip:
Phone #:	Work Phone #:	
Email Address:		

Single Divorced Married Widowed
 (For all married applicants: **Spouse must sign** and date below and have signature notarized.)

Spouse Name:	Spouse SSN:	Spouse DOB:
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BENEFICIARY	Primary Beneficiary Name:		
	Relationship:	SSN:	DOB:
	<input type="checkbox"/> Alternate Beneficiary Name:		
	Relationship:	SSN:	DOB:

Request for Ordinary Disability Retirement: Under the provisions of the Fairfax County Employees' Retirement System Ordinance, I hereby apply for Ordinary Disability Retirement because a disability prevents me from performing the duties of my position. The disability is described on the attached form. I have completed five or more years of service for Fairfax County.

Employee Signature: _____ Date: _____

Request for Service-Connected Disability: Under the provisions of the Fairfax County Employees' Retirement System Ordinance, I hereby apply for Service-Connected Disability Retirement because of a disability incurred in the performance of my duties which prevents me from performing the duties of my position. The disability is described on the attached form. I hereby acknowledge receipt of the "Preparing for Disability Retirement Guide". **Proof of applicant's birth must be attached.**

Employee Signature: _____ Date: _____

Spousal Acknowledgment (Married applicants: **Spouse must sign** and date below and have signature notarized.) I understand that no Joint and Last Survivor payment option is available so I will receive no retirement benefits after my spouse's death.

Signature of Spouse: _____ Date: _____

..... Notarization of this application is not required if the member is NOT married

TO BE COMPLETED BY NOTARY or other Court Official authorized to take acknowledgements

State of _____ City/County of _____

On this _____ day of _____, _____, the persons whose names are signed above, personally appeared before me and acknowledged the foregoing signatures to be his or hers, and having duly sworn before me, made oath that the statements made in the said instrument are true.

My commission expires _____

Date: _____ Notary Signature: _____ Registration #: _____

Release of Records Member's Statement

I hereby authorize my health care providers and previous employers to release any and all medical records on my previous physical condition and treatment to the Board of Trustees of the Employees' Retirement System and/or Board Investigator. For purposes of this release, health care providers shall include, but are not limited to, all physicians, psychologists, psychiatrists, clinics, hospitals, and governmental or quasi-governmental agencies. Medical records include, but are not limited to, medical reports, test results, and any other information bearing upon my physical or mental condition. This release also applies to any and all Employees' Personnel records including, but not limited to, my application for employment. The medical records and personnel records will be disclosed for the purpose of evaluating the member's application for disability retirement and may be disclosed to the members of the Board of Trustees, the staff of the Retirement Systems, the consulting physicians, experts and attorneys for the Retirement System, and the independent medical examiner chosen to evaluate the member. Such release shall remain valid until such time as I am no longer receiving disability benefits.

This statement of disability has been made as part of my application for disability retirement under the provisions of the Fairfax County Employees' Retirement System's Ordinance. This application represents a true and accurate statement of my medical condition.

Employee Signature: _____ **Date:** _____

Print Name: _____