Retirement Board of the
PARK EMPLOYEES' ANNUITY AND BENEFIT FUND
3500 S. Morgan Street
Suite 400
Chicago, Illinois 60609
Tel. # (312) 553-9265
Fax # (312) 553-9114
www.chicagoparkpension.org

Name: _____ Date: _____

PLEASE READ AND ANSWER ALL QUESTIONS

We have received notice of your **absence from service without pay.**

If you were carried "S", that is, sick without pay, for 8 consecutive days or more and wish to receive Ordinary Disability, you must properly file the enclosed Application and Benefit Recipient Form. (**NOTE: NO BENEFIT IS PAYABLE FOR ABSENCES OF LESS THAN 8 CONSECUTIVE DAYS).**

In order to qualify for Ordinary Disability, an employee must be under the constant care of a competent physician; otherwise, no benefit will be paid. Please complete and sign Page 1 of 2 of the Application Form for Disability and the Benefit Recipient Form (2 pages). Have your doctor complete and sign Page 2 of 2 of the Application Form for Ordinary Disability. Return them to us in the enclosed stamped envelope.

It is important that the application be returned promptly so that the Board may have a medical report from its own doctor during your period of illness. **IN ADDITION, AN APPLICATION FOR ORDINARY DISABILITY MUST BE FILED WITHIN 60 DAYS FROM THE LAST DAY YOU WERE IN PAY STATUS.** Should there be any delay in filing your application, the payments cannot be backdated more than 60 days from the date you file the application.

If you were carried "S" for a minimum of **8 CONSECUTIVE DAYS IN THE PRECEDING MONTH AND HAVE PROPERLY FILED YOUR APPLICATION AND BENEFIT RECIPIENT FORM,** your claim will be presented to the Retirement Board at its next regular meeting scheduled for **THURSDAY,** _____. In order for action to be taken at this meeting, the forms must be in our office by _____.

Ordinary disability, that is, sick benefit is paid once a month on the third Thursday of the month for an absence of 8 consecutive days or more in the preceding month.

Sincerely,

Benefits Department

WHEN APPLICABLE

Retirement Board of the
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ORDINARY DISABILITY (MATERNITY)

PLEASE READ CAREFULLY!!!

ORDINARY DISABILITY (MATERNITY) BENEFIT COVERS 8 WEEKS FROM THE DATE OF BIRTH FOR THE BIRTHING PARENT. BENEFITS FOR THE BIRTH OF A CHILD MAY BE EXTENDED UPON PROOF OF DISABILITY PURSUANT TO THE OD BENEFITS APPLICATION PROCESS.

PLEASE NOTE THE FOLLOWING:

THE DISABILITY PERIOD WILL NOT EXTEND BEYOND THE PRESCRIBED 8 WEEK PERIOD.

THE DISABILITY BENEFIT WILL BE REDUCED BY THE CHICAGO PARK DISTRICT BENEFIT TIME (i.e. vacation days, sick days, floating holidays) USED DURING THE ABOVE PERIODS.

IF YOU HAVE ANY FURTHER QUESTION OR HAVE ANY MEDICAL COMPLICATIONS, PLEASE CALL THE PENSION OFFICE IMMEDIATELY.

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APPLICATION for ORDINARY DISABILITY BENEFIT NON-JOB RELATED

Note: Return this form as soon as possible; Payment cannot be dated back more than 60 days from receipt of application.

Date: _____

I, _____
(Name of Employee) (Social Security No.) (Age)

residing at _____
(Address) City/State/Zip (Home Phone No.)

was taken ill on _____ and date when "S" time began _____
(Date) (Date)

and for the purpose of applying for benefits under the provisions of the law governing the operation of the PARK EMPLOYEES' ANNUITY AND BENEFIT FUND, submit herewith the answers to the following questions, which answers I hereby warrant to be true and correct.

1) When did you first see a physician for this illness? Date: _____
Where? (i.e. physician's office or elsewhere) _____

2) State physician's name: _____
Address & Phone Number: _____

3) What was your occupation when taken ill? Describe your usual duties. _____

4) What is the nature of the illness? Describe symptoms fully: Name part of body affected: _____

5) Were you hospitalized for this sickness? ☐ Yes ☐ No If YES, from _____ to _____
Name of Hospital: _____
Address: _____

6) When will you be able to return to work? _____

7) Have you had any medical or surgical treatment during the past five years? If so, detail briefly: _____

I HEREBY STATE THAT THIS CLAIM FOR ORDINARY DISABILITY SET FORTH IN THIS APPLICATION IS IN NO WAY CONNECTED WITH THE DUTIES ASSIGNED TO ME BY MY EMPLOYER, NAMELY THE CHICAGO PARK DISTRICT NOR DID IT ARISE OR OCCUR OUT OF MY EMPLOYMENT.

_____
(Signature of Employee)

PARK EMPLOYEES' ANNUITY AND BENEFIT FUND of CHICAGO

APPLICATION for ORDINARY DISABILITY BENEFIT NON-JOB RELATED

REPORT OF ATTENDING PHYSICIAN

The examination of _____
(Patient's Name)

1) When and where did you FIRST examine the above employee for this illness?
Date: _____ Place: _____
(Patient's home, your office or elsewhere)

2) What is the exact nature of illness? Give complete diagnosis of case: _____
_____
_____
_____

3) If a disease, is it - - - Acute? ☐ Chronic? ☐ Venereal? ☐

4) What operation, if any, did you perform? _____

5) Have there been any laboratory tests made? If so, what are the results? _____
_____
_____

6) Are there any complications that may prolong disability? _____
_____
_____

7) When and where did you LAST attend upon and prescribe for claimant?
Date: _____ Place: _____

8) On what date will employee be able to resume his/her assigned duties in the park service?
Please specify: _____

I, a practicing physician, duly registered as such under the laws of the State of Illinois, my registry number being _____, do hereby certify that the answers to the foregoing questions are complete and true, to the best of my knowledge, information and belief.

_____
(Signature of Physician)

Date: _____ Address: _____

Note: Please return this form as soon as possible; benefit payment cannot be dated back more than 60 days.

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BENEFIT RECIPIENT FORM

Note: This form, completed and signed, must be filed with the Park Employees' Annuity and Benefit Fund before any benefits will be paid for Ordinary Disability (Sick Benefit) or Duty Disability (Injury on Duty).

Applicant's signature (***read before signing***): _____ Date: _____

Address: _____

Phone: ( ) _____ Zip Code: _____

I, _____ do hereby state that I am eligible for disability benefits
(applicant's printed name)
from the Park Employees' Annuity and Benefit Fund.

CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ My disability, injury, illness, etc. **is not** work related

☐ My disability, injury, illness, etc. **is** work related

The cause of my disability, injury or illness, etc. is: _____

_____

_____

_____

I state that I am or was working for the following company, companies or entities during the last 365 days: (Include self employment. Also list the Chicago Park District).

Company: _____ Address: _____
City: _____ Phone: _____
Amount Earned: _____ Last day of employment: _____

Company: _____ Address: _____
City: _____ Phone: _____
Amount Earned: _____ Last day of employment: _____

Company: _____ Address: _____
City: _____ Phone: _____
Amount Earned: _____ Last day of employment: _____

(If more space is needed, use the reverse side of the paper)

BENEFIT RECIPIENT FORM

I further state that I have applied or may be qualified to receive benefits for this disability from the following company or companies. (List the Chicago Park District if application is or will be made.)

Company: _____ Address: _____

City: _____ Phone: _____

Position: _____ Date Disability Payments began: _____

Company: _____ Address: _____

City: _____ Phone: _____

Position: _____ Date Disability Payments began: _____

(If more space is needed for this section, use the space provided below.)

I further state that I am receiving income from sources other than the Chicago Park District as follows:

_____

_____

_____

_____

Outside from the above, I am receiving income from no other sources.

I further state that I have or intend to file a Workmen's Compensation or Occupational Disease claim for this disability, injury or illness against: (List the Chicago Park District, if you have or intend to file a claim against it.)

Company's Name: _____

Address: _____

Company's Name: _____

Address: _____

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ORDINARY DISABILITY INCOME – "S" TIME – IS TAXABLE
(In lieu of Federal Form W4S)

If you wish us to withhold from your ordinary disability check, please complete this form and return it. If you do not want taxes withheld, please note that you are liable for any tax due through estimated tax payments.

Name (please print or type): _____ SSN: _____

Present legal address: _____
Street Apt. #

_____
City /State Zip Code

I REQUEST VOLUNTARY INCOME TAX WITHHOLDING FROM MY BENEFIT PAYMENTS AS AUTHORIZED UNDER THE INCOME TAX LAW.

(Enter the amount of Federal Income Tax to be withheld from each payment on the line below).
Note: IT CANNOT BE LESS THAN $88.00 PER MONTH.

$ _____

Signature of Employee: _____ Date: _____

RETURN TO: Park Employees Annuity and Benefit Fund of Chicago
3500 S Morgan Street Suite 400 Chicago, IL 60609

CUT ALONG THIS LINE – PLEASE KEEP THIS PORTION FOR YOUR RECORDS

TO BE KEPT BY THE BENEFIT RECIPIENT

Under the Income Tax Regulations, the minimum amount of Federal Income Tax that can be withheld is $22.00 per week ($88.00 per month). The amount to be withheld must be stated on a monthly basis. If you are off less than a month, the amount will be prorated. The minimum amount of sick pay remaining after withholding must be at least $10.00.

Requested Federal Withholding Tax from each disability payment $_____.

Dated: _____

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Concentra

Instructions

To process the application, the Fund requires that our designated physician (Concentra) approves the medical examination you provided.

Please complete Section 1 of the attached Physician Statement for Disability Benefits, Concentra will complete Section 2.

Also, please complete the Concentra HIPAA Release to allow the Fund to receive copies of your medical records.

There is no need to visit a Concentra location. Return the forms along with the disability application back to our office.

Thank you,

Benefits Department
PEABF
3500 S. Morgan St. Suite 400
Chicago, IL 60609
Direct: (312) 553-9265
Fax: (312) 553-9114

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Office #

PHYSICIAN STATEMENT FOR DISABILITY BENEFITS

TO BE COMPLETED BY THE EMPLOYEE

Section 1: Applicant Information

Name:	Concentra Location:
Date of birth:	Phone:
Current address **(Cannot use PO Box)**:	
City: State: ZIP Code:	

AUTHORIZATION: I authorize disclosure to the PEABF (and its representatives) of all employment, medical and mental health records, and information necessary to process my claim for disability benefits in accordance with the Illinois Pension Code. A photocopy of this authorization shall be as effective and valid as the original.

Signature: Date: _____ / _____ / _____

Section 2: TO BE COMPLETED BY THE PEABF PHYSICIAN (CONCENTRA)

The above-named Employee is seeking disability benefits from the Park Employees' Annuity and Benefit Fund of Chicago (PEABF). The following requested information is necessary for the Board to determine whether or not disability benefits should be granted in accordance with the Illinois Pension Code. Failure to provide full and complete information will cause delay or denial of a disability benefit.

Date of evaluation: _____ / _____ / _____

Description of illness / injury: _____

Summary of examination and remarks based on evaluation of patient and review of Attending Physician Statement.

☐ Not able to determine disability. Available documentation and/or exam is insufficient to make an informed recommendation.

☐ Period of disability based on evaluation: disability recommended THROUGH _____ / _____ / _____

Is patient able to return to work as of this date? ☐Yes ☐No

Certification: I certify that I have personally examined the patient and the information contained in this form is true and accurate to the best of my knowledge.

Name (print): _____ Degree: _____

Physician/Provider Tax ID: _____ Medical Specialty: _____

Address: _____ Phone: (____) _____

Signature: _____ Date: _____ / _____ / _____

Concentra®

Employer Services-Authorization For Disclosure of Protected Health Information (PHI) HIPAA Release

I authorize Concentra to use and disclose protected health information (PHI) from the record(s) of:

Patient's Name: _____ Birthdate: _____

Address: _____

Purpose of Disclosure

☐ Occupational Injury ☐ Occupational Non-injury ☐ Other

Confirmation of Who May Receive Copies of Your Records

Employer or Entity Name: _____

Address: _____ City: _____ St: _____ Zip: _____

Fax Number: _____ Confirmation Telephone Number: _____

In Connection With This Authorization:

- I am aware that copies of records for services rendered on _____ (date of service) and subsequent related visits containing PHI which may include the results of tests or evaluations, including diagnosis, medical history, transcription notes, tests, and evaluations performed that my treating clinician(s), employer, prospective employer or third party entity has ordered or requires.
- I give Concentra authorization to release to my employer, insurance company, and/or their representatives any medical information, including any psychotherapy notes, psychiatric information, sexually transmitted diseases, alcohol and drug abuse and/or HIV/AIDS status, which is obtained as part of the evaluation and/or treatment for this work related injury/illness, or employment-related examination.
- I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that I may revoke this authorization at any time, except to the extent that action has already been taken by Concentra, by providing a written request to the Center where my care was provided.
- I understand that Concentra may not deny treatment if I do not complete this authorization form, but may deny services when the services are only to create PHI for disclosure to a third party.
- I have a right to not sign this authorization or to limit the information I authorize to be disclosed to the minimum necessary, however, refusal to sign this authorization or to limit disclosure of my PHI may violate a condition of employment or prospective employment.
- I may revoke this authorization at any time, but I must do so by submitting a written notice to the Concentra center where I received services. However, if I am here for a work-related visit that is subject to Workers' Compensation, under some state laws I am not allowed to revoke this authorization.
- I understand that this authorization expires one year from the date of execution, unless revoked in writing, or a shorter expiration date is required by applicable state law.
- I have a right to receive a copy of this authorization.

_____ _____

Patient/Patient's Representative Signature Date:

_____

Printed Name of Patient's Representative

_____

Explanation of your legal right to sign for Patient

For HIPAA questions related to this form, please contact the Concentra Privacy Office at 1-800-819-5571.

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