

BOARD OF TRUSTEES
- OF THE -
FIRE FIGHTER'S PENSION AND RELIEF FUND
FOR THE CITY OF NEW ORLEANS
3520 General DeGaulle Suite 3001
New Orleans, La 70114
504-366-8102
504-366-8103 fax

APPLICATION FOR A DISABILITY RETIREMENT BENEFIT
(New System Firefighter)

I hereby apply for my Disability Retirement Benefit from the Firefighters' Pension and Relief Fund for the City of New Orleans ("Fund") and agree to be bound by the Louisiana Statute establishing the Fund, La. R. S. 11:3361 *et seq.*, and the Rules and Regulations thereunder. I hereby request the Board of Trustees of the Fund to determine my eligibility to receive my Disability Retirement Benefit and to place my name on the pension rolls. I understand that this Application will be reviewed by the Board only after my application file is complete and all requested documentary or other evidence requested by the Board has been furnished. I have submitted, along with this Application, the necessary medical reports, physician reports or statements and any other documentary evidence necessary to support this Application for Disability Retirement Benefit.

A. GENERAL INFORMATION

1. Firefighters' Name:

Last	First	Middle	Ext.
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2. Address:

Number & Street	City	State	Zip Code
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3. Telephone No.: _____ Alternative Telephone No.: _____

4. Social Security Number: _____ - _____ - _____

5. Email: _____

6. Date of Birth _____/_____/_____
(Please submit verification of date of birth, i.e. certified copy of birth certificate)

7. Date of employment as a Firefighter _____/_____/_____

8. Are you an Active Firefighter: ()Yes ()No

13. Have you served in the Armed Forces of the United States? ()Yes ()No

If yes, submit verification of your service and fill in the information below.

Branch of Service: _____

Date Entered: _____

Date Discharged or Separated: _____

B. DISABILITY RETIREMENT BENEFIT

I understand that any Disability Retirement Benefit to which I am entitled will be determined by the Board of Trustees, based on whether or not my incapacity from a service-connected or non-service connected injury or illness and according to the degree of my disability.

I understand that once I retire and commence receipt of the following Disability Retirement Benefits, I cannot select an alternative form or change the type of benefit.

I request the following Disability Retirement Benefit:

1. () **Non-Service Connected Disability Retirement Benefit**: I understand that I am entitled to a Non-Service Connected Disability Retirement Benefit if the Board determines that I acquired a total and permanent physical or mental disability that is not a direct result of a service-incurred injury or illness, and that I am incapable of performing my duties as a Firefighter. I understand that a Non-Service Connected Disability Retirement Benefit will be determined as a percentage, based on my years of service, and will be a percentage of my average compensation earned during my last year preceding my Disability Retirement Date as follows:
 - a. () If I have completed ten (10) Years of Service or less as an Active Firefighter, I am entitled to receive a Disability Retirement Benefit equal to thirty percent (30%) of my average Compensation during the last Year of Service immediately preceding the Disability Retirement Date.
 - b. () If I have completed more than ten (10) but not more than fifteen (15) Years of Service as an Active Firefighter, I am entitled to receive a Disability Retirement Benefit equal to forty percent (40%) of my average Compensation during the last Year of Service immediately preceding the Disability Retirement Date.
 - c. () If I have completed more than fifteen (15) Years of Service as an Active Firefighter, I am entitled to receive a Disability Retirement Benefit

equal to fifty percent (50%) of my average Compensation during the last Year of Service immediately preceding the Disability Retirement Date.

2. () **Service-Connected Disability Retirement Benefit**

- 1) () **66 2/3% Disability Retirement Benefit** I understand that I am entitled to a 66 2/3% Disability Retirement Benefit if the Board determines that I acquired a total and permanent physical or mental disability that is a direct result of a service-incurred injury or illness, and that I am incapable of performing my duties as a Firefighter and I am unable to hold any other meaningful or gainful employment.

I understand that the amount of my Service-Connected Disability Retirement Benefit will be the greater of:

1. Two-thirds of the salary I am receiving on my Disability Retirement Date; or
2. The amount of my Service Retirement Benefit if I am otherwise eligible to receive my Service Retirement Benefit.

- 2) () **50% Disability Retirement Benefit** I understand that I am entitled to a 50 % Disability Retirement Benefit if the Board determines that I acquired a total and permanent physical or mental disability that is a direct result of a service-incurred injury or illness, and that I am incapable of performing my duties as a Firefighter.

I understand that the amount of my Service Connected Disability Retirement Benefit will be the greater of:

1. Fifty (50%) percent of the salary I am receiving on my Disability Retirement date; or
2. The amount of my Service Retirement Benefit, if I am otherwise eligible to receive my Service Retirement Benefit.

C. ELECTION OF BENEFIT PAYMENT OPTION

I understand that, pursuant to La. R. S. 11:3385, I have the option to receive my Disability Retirement Benefit in a retirement allowance payable throughout life, or I may elect to receive the actuarial equivalent, at the date of retirement, of my retirement allowance in a reduced retirement allowance payable throughout life, with the provision that: *the form of a Single Life Annuity over my life with no further payments at my death, as a Reduced Annuity payable over my life with no further payments at my death plus an initial lump sum amount, or as a Reduced Annuity payable over my life with Survivor benefits payable to my Designated Beneficiary.*

I elect to receive my Disability Retirement Benefits in the following manner:

Single Life Annuity Option:

My Disability Retirement Benefit will be paid to me in equal periodic payments each month for as long as I live.

Reduced Annuity with Lump Option Payment to Designated Beneficiary:

My Disability Retirement Benefit will be paid to me in equal periodic payments each month for as long as I live, with any unpaid balance of the actuarial value of my Accumulated Contributions to be paid to my Designated Beneficiary.

Joint and Survivor Annuity Option:

My Disability Retirement Benefit will be paid to me for as long as I live, in equal periodic payments each month, as actuarially calculated, based on the joint life expectancy of me and my Designated Beneficiary, with monthly payments continuing to my Designated Beneficiary, for Life.

50% Survivor Annuity Option:

My Disability Retirement Benefit will be paid to me for as long as I live, in equal periodic payments each month and with monthly payments equal to 50% of my monthly benefit continuing after my death to my Designated Beneficiary, for life.

Other:

My Disability Retirement Benefit will be paid to me in my combination of equal monthly payments, as described below, for as long as I live with a continuing benefit payable to my Designated Beneficiary for life. My Disability Retirement Benefit will be paid in the following manner:

(Describe the manner of payment to you and your Designated Beneficiary; however, the total benefit payable to both must equal the actuarial equivalent to your Disability Retirement Benefit.)

If you have elected an optional form of payment of your Disability Retirement Benefit, you must designate a Beneficiary on the Designation of Beneficiary form.

Partial Lump-Sum Option Payment (PLOP):

My Disability Retirement Benefit will be paid to me for as long as I live in a reduced equal monthly payments, plus an initial lump sum benefit not to exceed an amount equal to my monthly benefit multiplied by sixty, with no further benefits to be paid at my death. I understand that my monthly retirement benefit will be actuarially reduced based on the lump-sum amount I select and my age at retirement.

I also understand that any Cost of Living adjustment granted by the Board of Trustees will be based only on the reduced monthly benefit and not on the partial lump sum benefit.

Below, please select the number of months you wish to receive as your partial lump-sum payment.

I, _____, hereby select to receive my PLOP benefit based on _____ (1-60) months. (**May not exceed 60 months.**)

I understand that I must notify the Trustees of the Fund, in writing, if the above general information should change.

I have attached the necessary verifications, reports and documents to this Application and understand that this Application for Disability Retirement Benefit will not be considered by the Board of Trustees until this Application is completed in full and all documents are submitted herewith.

I certify that the above information is true and correct to the best of my knowledge and belief.

Date _____

Signature of Firefighter

SPOUSAL ACKNOWLEDGEMENT

(If you are married, your spouse must execute this Acknowledgment)

STATE OF _____

PARISH OF _____

BEFORE ME, this _____ day of _____, _____, personally came and appeared: _____, who being duly sworn did depose

and say:

As the legal spouse of Firefighter _____, I hereby acknowledge the above retirement benefit distribution election of my spouse, I further understand that my spouse's benefit election and his designated beneficiary, of which I have knowledge, may preclude or reduce my receipt of benefits from the Firefighters' Pension & Relief Fund in the event of my spouse's death.

Spouse's Signature

Printed Name

Address

Telephone Number

Social Security Number

SWORN TO AND SUBSCRIBED
BEFORE ME, NOTARY, ON THIS
_____ DAY OF _____, _____.

NOTARY PUBLIC _____

Filed with Board of Trustees: _____

TO WHOM IT MAY CONCERN:

RELEASE

I hereby authorize you to permit _____, on behalf of the Trustees of the Firefighters' Pension & Relief Fund for the City of New Orleans ("Fund."), to inspect and copy any and all medical records and documents maintained by your office, which in the Trustees' judgment will support my request to receive a Disability Retirement Benefit from the Fund, by reason of my mental or physical or total and permanent disability.

Date: _____

Signature of Active Firefighter

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By signing below, for the purpose of establishing my Disability or entitlement to benefits from the City, I hereby authorize the Firefighter's Pension and Relief Fund for the City of New Orleans to release any information or records maintained by the Fund, regarding my present and past employment as a firefighter.

Date: _____

Sign: _____