

# City of Fort Lauderdale General Employees' Retirement System

## Application for Disability Benefits

I hereby submit this application to the Board of Trustees for Disability Benefits and provide to them the following information:

**Type of Disability** you are applying for:     On-the-Job             Off-the-Job

**\*Type or Print\***

Name \_\_\_\_\_ Soc Sec No. \_\_\_\_\_

Home Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone No. \_\_\_\_\_

Date of Injury or Illness \_\_\_\_\_

Last Date Worked \_\_\_\_\_

Describe the nature of the disabling condition \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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List below the information of **TWO OR MORE** medical doctors who have treated you regarding your disabling condition **WITHIN THE PAST SIX MONTHS**:

Doctor 1: \_\_\_\_\_

Field or Specialty: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

Doctor 2: \_\_\_\_\_

Field or Specialty: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

Doctor 3: \_\_\_\_\_

Field or Specialty: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

Doctor 4: \_\_\_\_\_

Field or Specialty: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_