Office of the New York State Comptroller

NYSLRS

New York State and Local Retirement System

110 State Street, Albany, New York 12244-0001

Please type or print clearly in blue or black ink

Deceased NYSLRS ID

Received Date

Deceased Social Security Number [last 4 digits]

XXX-XX- | | | | |

Application for Conversion of Service or Disability Retirement to Accidental Death Benefit for Victims of the 2001 World Trade Center Disaster

RS 6418-W

(Rev.12/23)

Retirement System [check one]

Employees' Retirement System (ERS) ☐

Police and Fire' Retirement System (PFRS) ☐

Please return this application to the Retirement System in an envelope marked "Personal and Confidential Mail Drop 7 1"

INSTRUCTIONS: Please print plainly or type. The application must be signed on the reverse side.
Please call our Call Center at 1-866-805-0990 if you need help completing this application.

Information About The Deceased Pensioner (please print)

1. Name of Deceased Pensioner: (First, Middle Initial, Last)	2. Pensioner's Date of Birth:
3. Pensioner's Date of Death:	4. Cause of Death:

5. LIST BELOW ALL DOCTORS WHO TREATED THE DECEASED: (Use the last box** to name the doctor who performed autopsy.)

Primary Care Physician:	Doctor:	Doctor:
Internal Med/Family Practitioner:	Medical Specialty:	Medical Specialty:
Street:	Street:	Street:
City, State and Zip Code:	City, State and Zip Code:	City, State and Zip Code:
Doctor:	Doctor:	**Autopsy Doctor **:**
Medical Specialty:	Medical Specialty:	Medical Specialty:
Street:	Street:	Street:
City, State and Zip Code:	City, State and Zip Code:	City, State and Zip Code:

6. LIST BELOW ALL HOSPITALS WHERE THE DECEASED WAS TREATED: (Use additional sheets if required) (If none, so state)

Hospital:	Dates of Admission:	Hospital:	Dates of Admission:
Street:		Street:	
City, State and Zip Code:		City, State and Zip Code:	

IMPORTANT – You must complete other side

7. LIST BELOW ALL HOSPITALS WHERE THE DECEASED WAS TREATED: (Use additional sheets if required) (If none, so state)			
Hospital:	Dates of Admission:	Hospital:	Dates of Admission:
Street:		Street:	
City, State and Zip Code:		City, State and Zip Code:	

INFORMATION ABOUT THE APPLICANT		
8. Name: (First, Middle Initial, Last)	9. Date of Birth:	
10. Address: (Including Street, City, State and Zip Code)	11. Telephone Numbers: HOME ( ) WORK ( ) CELL ( )	
12. Relationship to Deceased:	13. If Spouse, married to deceased on:	14. Place of Marriage:

15. LIST ALL CHILDREN OF DECEASED PENSIONER:			
NAME:	DATE OF BIRTH:	NAME:	DATE OF BIRTH:

16. YOU RECEIVING WORKERS' COMPENSATION BENEFITS? ☐ YES ☐ NO CLAIM NO._____

17. TO BE ELIGIBLE TO RECEIVE THIS BENEFIT:

1) you must be an eligible beneficiary, and
2) the retiree had to have filed a World Trade Center Notice form with the New York State and Local Retirement System on or before September 11, 2022, or would have met the criteria if not already retired on an Accidental Disability, and
3) the retiree has not be retired for more than 25 years at the time of death.

For more information, including a list of eligible beneficiaries, please visit our website at www.osc.ny.gov/retire.

18. As required, I have attached the Death Certificate of the deceased pensioner, documentary evidence of my birth, my Marriage Certificate and documentary evidence of the birth of the above named children.

I certify that the information on my application is true and complete to the best of my knowledge. I further certify that I am aware that any false statement I knowingly make or permit to be made on this or any record of the Retirement System constitutes a crime punishable by potential incarceration and other sanctions.

Your Signature:_____ Date:_____

ACKNOWLEDGEMENT TO BE COMPLETED BY A NOTARY PUBLIC

State of _____ County of _____ On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____

NOTARY PUBLIC (Please sign and affix stamp)

***Social Security Disclosure Requirement:** In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of your Social Security account number is mandatory pursuant to Sections 11, 34, 311 and 334 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

Personal Privacy Protection Law: The Retirement System is required by law to maintain records to determine eligibility for and calculate benefits. Failure to provide information may interfere with the timely payment of benefits. The System may be required to provide certain information to participating employers. The official responsible for record maintenance is the Director of Member and Employer Services, NYS and Local Retirement System, Albany, NY 12244; call toll-free at 1-866-805-0990 or 518-474-7736 in the Albany Area

Office of the New York State Comptroller
NYSLRS
New York State and Local Retirement System
110 State Street, Albany, New York 12244-0001

Please type or print clearly in blue or black ink

Received Date

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

RS 6429
(Rev. 05/22)

Patient Name: (First, Middle Initial, Last)	Date of Birth:	Social Security Number: **XXX-XX-**
Patient Address: (Including Street, City, State and Zip Code)		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in item 8(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in item 8(a), I specifically authorize release of such information to the person(s) indicated in Item 7.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from disclosing such information, without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (1-888-392-3644) or (212-961-8650). This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider(s) listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
5. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 8(b).**

6. Name and address of health care provider(s) or entity(ies) to release this information:

7. Name and address of person(s) or category of person to whom this information will be sent:
New York State and Local Retirement System, Mail Drop 7-1, 110 State Street, Albany NY 12244

8. (a) Specific information to be release:

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, insurance records, and records sent to you by other health care providers.

☐ Other: _____
_____

Include: *(Indicate by Initialing)*
_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____ to discuss my health
Initials — Name of individual health care provider

information with my attorney or governmental agency listed here:

New York State and Local Retirement System
(Attorney/Firm Name or Government Agency Name)

9. Reason for release of information: ☐ At the request of individual ☐ Other:	10. This authorization will expire at the completion of the disability retirement application process:
11. If not the patient, name of person signing form:	12. Authority to sign on behalf of patient:

_____ _____
Signature of patient representative authorized by law — Date

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts**.