



Office of the New York State Comptroller
 New York State and Local Retirement System
 Employees' Retirement System
 Police and Fire Retirement System
 110 State Street, Albany, New York 12244-0001

RECEIVED

Application for World Trade Center Accidental Disability Presumption

RS 6047-W

(8/05)

INSTRUCTIONS: Please print clearly or type. The application must be signed and notarized on reverse side.

Please Note: To be eligible for this benefit, you must meet the following two requirements:
 1) Successfully passed a required physical examination upon entry into public service that did not disclose evidence of the qualifying condition or impairment of health. Were you required to take such a physical? YES ____ NO ____ If yes, please provide name of employer who required the physical exam: _____

2) Participated for a minimum of 40 hours (or injured on September 11, 2001 or September 12, 2001, preventing you from performing 40 hours of work) in the rescue, recovery, or clean up operations at any one of the following sites between September 11, 2001 and September 12, 2002:

Locations	Dates	Name and Address of Employer/Organization* Under Which Work Was Performed
World Trade Center Site		
Fresh Kills Landfill		
New York City Morgue		
Temporary Morgue on pier locations on the west side of Manhattan		
Barges between the west side of Manhattan and the Fresh Kills Landfill		

Total number of hours worked: Over 40 ____ Under 40 ____

*Your Employer/Organization will be contacted to verify your involvement.

If you meet these two requirements, you may be eligible for the benefit of this disability presumption.

INFORMATION ABOUT YOU (If you are already retired, you must file this form by **June 14, 2007**.)

1. NAME:	2. SEX: M <input type="checkbox"/> F <input type="checkbox"/>	3. ADDRESS:
4. REGISTRATION NUMBER: or RETIREMENT NUMBER, if retired:	5. SOCIAL SECURITY NUMBER**:	
7. TELEPHONE NUMBER: HOME () WORK ()	6. DATE OF BIRTH: / /	
9. PAYROLL TITLE:	8. CURRENT EMPLOYER: If retired, last public employer:	
	10. Are you a member of both the New York State and Local Employees' Retirement System and the Police and Fire Retirement System? <input type="checkbox"/> YES <input type="checkbox"/> NO	

11. I am permanently disabled because of the following condition or impairment of health:

12. HAVE YOU APPLIED FOR AND/OR RECEIVED WORKERS' COMPENSATION? IF YES, LIST DATES OF INCIDENT(S) AND WORKERS' COMPENSATION NUMBER(S).

Tiers 1, 2 & 3 Accidental Disability Benefits are reduced by Workers' Compensation benefits. If Workers' Compensation benefits are payable, you must apply for them.

--

****NOTE:** 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. Your number will be used in identifying your 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 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 Services, NYS and Local Retirement System, Albany, NY 12244; (518) 474-7736.

13. I HAVE BEEN TREATED BY THE FOLLOWING DOCTORS: (Use additional sheets if required.)

Doctor	Doctor	Doctor
Street	Street	Street
City, State and Zip Code	City, State and Zip Code	City, State and Zip Code
Doctor	Doctor	Doctor
Street	Street	Street
City, State and Zip Code	City, State and Zip Code	City, State and Zip Code

14. LIST HOSPITALIZATIONS (If none, please state. Use additional sheets if required.)

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

15. IF YOU ARE NOT ALREADY RETIRED, PLEASE PROVIDE INFORMATION ABOUT YOUR INTENDED BENEFICIARY

***Social Security Number Required (see statement on reverse side)*

Beneficiary	Relationship to you (if any)	
Street	Beneficiary's Social Security Number**	
City, State and Zip Code	Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>

16. I do hereby waive the confidential character of any records, reports or data relating to my mental or physical condition and hereby authorize the release of all such information by physicians, institutions and agencies including the **Social Security Administration** and the **Veterans Administration**, to the Medical Board of the New York State and Local Retirement System. Records, reports or data shall include, but not be limited to, a Social Security Disability Award Certificate, Social Security Form 831, HIV related, drug abuse and alcoholism information. This authority waives any rights of privacy between myself and my physician, institution or agency. A copy of this waiver may be used in lieu of the original.

I certify that the information contained on this form is true.

Signature (Sign Name in Full)

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)