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

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

RECEIVED

Application for World Trade Center Accidental Disability Presumption

RS 6047-W

(Rev. 9/18)

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

INFORMATION ABOUT YOU		
1. NAME	**2. SEX:** ☐ **M** ☐ **F**	**3. ADDRESS:**
4. REGISTRATION NUMBER: or **RETIREMENT NUMBER, if retired:**		**5. SOCIAL SECURITY NUMBER*:** XXX-XX-
		6. DATE OF BIRTH / /
7. TELEPHONE NUMBERS: **HOME ( )** **WORK ( )** **CELL ( )**		**8. CURRENT EMPLOYER:** **If retired, last public employer:**
9. PAYROLL TITLE		
10. I AM PERMANENTLY DISABLED BECAUSE OF THE FOLLOWING CONDITION OR IMPAIRMENT OF HEALTH:		
11. FOR UNITED STATES TAX WITHHOLDING AND REPORTING PURPOSES (PLEASE CHECK ONE), I AM A: ☐ **U.S. CITIZEN** ☐ **RESIDENT ALIEN** ☐ **NONRESIDENT ALIEN**		

12. HAVE YOU FILED A WORLD TRADE CENTER NOTICE FOR MEMBERS AND RETIREES OF THE NEW YORK STATE AND LOCAL RETIREMENT SYSTEM (FORM RS 6047-N)? ☐ **Yes** ☐ **No**

YOU MUST HAVE FILED A WORLD TRADE CENTER NOTICE BY SEPTEMBER 11, 2022.

Medical Record Information prior to September 11, 2001

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

Primary Care Physician	Doctor	Doctor
Internal Med/Family Practitioner	Medical Speciality	Medical Speciality
Street	Street	Street
City, State and Zip Code	City, State and Zip Code	City, State and Zip Code

14. LIST HOSPITALIZATIONS, IF ANY. (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	

Medical Record Information after September 11, 2001

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

Primary Care Physician	Doctor	Doctor
Medical Speciality	Medical Speciality	Medical Speciality
Street	Street	Street
City, State and Zip Code	City, State and Zip Code	City, State and Zip Code
Doctor	Doctor	Doctor
Medical Speciality	Medical Speciality	Medical Speciality
Street	Street	Street
City, State and Zip Code	City, State and Zip Code	City, State and Zip Code

16. LIST HOSPITALIZATIONS, IF ANY. (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	

17. INFORMATION ABOUT YOUR INTENDED BENEFICIARY

Beneficiary	Relationship to you (if any)
Street	Date of Birth
City, State and Zip Code	Sex

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

Applicant Name / Title (Please Print)

Applicant Signature (Sign Name in Full) / Date

RELATIONSHIP TO MEMBER: ☐ Self ☐ Employer ☐ Other _____

(If applicant is not the member or employer, you must submit original documentation that authorizes you to file)

***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 Section 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 Systems, Albany, NY 12244; 518-474-7736.