Pension Board

Public Safety Complex
1650 Huron St.
Knoxville, TN 37917
www.cokpension.org

APPLICATION FOR DISABILITY PENSION BENEFITS

Please use additional pages as necessary to completely answer each question.

PART 1: PERSONAL INFORMATION

Name:_____ Employee ID:_____

DOB:_____

Address:_____

City:_____ State:_____ Zip Code: _____

Telephone:_____ Telephone:_____

Email Addresses:_____

Department:_____ Hire Date:_____

Job Title:_____

Name of Supervisor/Section Chief:_____

Supervisor's Phone number:_____

In-Line of Duty ☐ Not-in-Line of Duty ☐

PART 2: ILLNESS/INJURY

Date of Injury/Illness: _____

Last day physically worked for the City (not last day paid): _____

Body part(s) affected (i.e. knee, elbow, etc.): _____

In your own words, describe in as much detail as you can the nature of your illness or injury (i.e. what hurts and why?):

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List all medical providers seen for illness/injury (Include names, complete mailing addresses, and telephone numbers for each physician. Include the date range for treatment and whether they are currently treating you.):

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In your own words, describe the treatment you have received and identify the physician or medical provider providing the treatment:

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List all medications you are taking, including over-the-counter medications and indicate which physician prescribed each of them:

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Have you been released from treatment? ☐ Yes ☐ No

If yes, when? _____

Have you been released to return to work? ☐ Yes ☐ No

If yes, do you have any restrictions? ☐ Yes ☐ No

Please Describe: _____

If no, do you expect to be released to return to work? ☐ Yes ☐ No

Why or why not? _____

_____

Is your illness/injury expected to improve? ☐ Yes ☐ No

Why or why not? _____

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_____

Have you received a disability rating from any medical provider? ☐ Yes ☐ No

If yes, describe your disability rating and any restrictions:_____

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In your own words, describe in as much detail as possible how your illness/injury affects your ability to do your job:

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Are you receiving or have you received any other disability benefit from any source for the same illness/injury? ☐ Yes ☐ No

If yes, what source? _____

Please provide correspondence listing the award and any adjustments to your award.

Have you applied for Social Security Disability benefits? ☐ Yes ☐ No

If yes, what is the status of your application? _____

PART III: IN LINE OF DUTY DISABILITY (If you are not applying for an In Line of Duty Disability Pension, please skip to Part IV)

Were you injured on the job? ☐ Yes ☐ No

Did you report the injury to your supervisor? ☐ Yes ☐ No

Did you complete an incident report? ☐ Yes ☐ No

Did you seek immediate medical attention? ☐ Yes ☐ No

If yes, where did you go and who did you see? _____

_____

If no, please explain why, as well as where and when you first sought treatment:

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In your own words, describe in as much detail as possible how you were injured, including where you were and what you were doing at the time of your injury:

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Did you make a claim for worker's compensation? ☐ Yes ☐ No

If yes, are receiving benefits or was a settlement reached? ☐ Yes ☐ No

Were you denied benefits? ☐ Yes ☐ No

Have you reached maximum medical improvement? ☐ Yes ☐ No

Have you been approved to return to work without restrictions? ☐ Yes ☐ No

Have you been approved to return to work with restrictions? ☐ Yes ☐ No

If yes, describe restrictions:_____

Have you ever been previously treated for the same illness or an injury to the same body part? ☐ Yes ☐ No

If yes, please describe prior illness/injury, including date of illness/injury, medical providers seen, and treatment received:

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PART IV: MEDICAL RECORDS

Attach all medical records for all treatment sought and received for the illness/injury described above.

This application is not complete and will not be accepted for processing unless all medical records are attached. If you submit this application without the medical records attached, it will be returned to you for completion.

I CERTIFY THAT ALL STATEMENTS AND INFORMATION PROVIDED HEREIN ARE TRUE AND ACCURATE.

Signature:_____

Date:_____

RECEIVED AND ACKNOWLEDGED BY THE PENSION BOARD:
DATE: _____ BY: _____