APPLICATION FOR DISABILITY BENEFITS

TO THE BOARD OF COMMISSIONERS: In accordance with the provisions of **Section 14, Disability Payments of Title 36-21-190,** I hereby make application for disability benefits. I understand that I must be totally or permanently disabled as a result of a heart attack or of an injury received in the line-of-duty as a firefighter and not as a result of misconduct. I am aware that this benefit may not be paid to me for longer than twenty-four (24) calendar months. As an applicant for these benefits, I am also aware that the Board shall have the right to require an examination by one or more physicians on behalf of the Board and at its expense as required by Law. This expense is limited to the examination.

1. Name ______________________________ 2. Present Age______________

3. Social Security Number______________________________ 4. Membership No.____________

5. Employer immediately prior to your disability______________________________

6. Date of your last active employment as a Firefighter______________________________

7. Your job title______________________________

PLEASE CHECK THAT WHICH IS APPLICABLE:

8._____I have been terminated or retired from my department; therefore, no monthly contributions from me will be required.

9._____I have not been terminated or retired by my department. I understand that it is my responsibility to notify your office at such time as I terminate or retire from my position as a firefighter. Upon such notification, I will discontinue the monthly $20.00 contribution. Otherwise, I will remit my $20.00 contribution by personal check by the 10th each month.

10. Name of physician______________________________ 11. Telephone #______________

12. Address of physician______________________________

13. **OATH: I do hereby verify that the information furnished above is true and correct to the best of my knowledge and that if I am again actively employed in any capacity, I will notify the Executive Director at which time my disability payments will be stopped.**

14. Signature of Applicant ______________________________ Date ____________

15. Mailing address of Applicant______________________________

16. Telephone #______________________________

17. Beneficiary______________________________ 18. Social Security #______________________

19. Mailing Address of Beneficiary______________________________

State of Alabama, County of________________________

On this _____ day of _______________, ________, the above named______________________________

personally appeared before me, and made oath that the statements made above are true.

Signature of Notary Public______________________________

TO BE FILLED IN BY EMPLOYER AT TIME OF DISABILITY

1. Date of last active service of firefighter ______________________________

2. Has firefighter returned to work?__________ If so, give date________________________

3. Has the firefighter retired?_________ Date of Retirement ________________________

4. Approved by______________________________ Date ______________
   (Signature of Chief of Department)