PARK EMPLOYEES' ANNUITY
RETIREMENT BOARD
AND BENEFIT FUND

55 E. Monroe Street, Suite 2720
Chicago, Illinois 60603
Tel. # (312) 553-9265
Fax # (312) 553-9114
www.chicagoparkpension.org

Name: _____ Date: _____

PLEASE READ AND ANSWER ALL QUESTIONS

We have received notice of your **absence from service** because of an injury sustained while on duty.

1) In order to receive your Pension Fund benefits, you must complete and sign the enclosed forms for Duty Disability Benefit ("DDB") and the Benefit Recipient Form.

2) Have your attending physician or employer approved medical facility complete and sign the "DDB"

3) Return them to us in the enclosed stamped envelope.

4) These benefits include the Fund's portion of the statutory benefit, **the service credit for the period of disability and the death benefit payment credit.**

You are entitled to receive 75% of your gross salary during the period you are certified as injured on duty **LESS ANY COMPENSATION PAID BY THE CHICAGO PARK DISTRICT** under the Workmen's Compensation Act. It is necessary that we know the amount of the compensation paid you before any payment can be made by this Fund. We have made a request for this information from the Chicago Park District.

(Note: Any compensation you received in conjunction with a settlement, can be used as an offset of compensation received from this Pension Fund. - Chapter 40, Article 12, Section 141 of the Illinois Compiled Statutes).

Your application **must be filed in this office no later than** _____ **before** our next Board meeting, which is scheduled for THURSDAY _____.
If notice of the compensation allowance has been received from the Chicago Park District, your application will be presented to the Board at this meeting for authorization of payment.

Sincerely,

Deanna Terranova
Claims Technician

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PLEASE READ THIS STATEMENT

IT IS VITAL AND COULD INCREASE THE AMOUNT IN ANY DUTY DISABILITY PAYMENT TO YOU

TO WHOM IT MAY CONCERN:

According to our Pension Statute, Chapter 108-1/2, 12-140 Duty Disability Benefit, it states that an employee shall receive a further benefit of $20.00 per month on account of each eligible minor child (as prescribed in Section 12-137, see below), but the combined benefit to the employee and children shall not exceed the annual salary at the date to such disability less the sums that would be deducted from his salary for service annuity and spouse's service annuity.

Section 12-137 defines an eligible minor child as any lawful child or adopted child who is under 18 years of age. **You must submit any or all birth or adoption records upon filing** for Duty (Injury) Disability to receive further benefits.

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APPLICATION for DUTY DISABILITY BENEFIT

This form should be filled out by the employee and his physician or Medical Facility as soon as possible following the injury for any payment to be made.

FOR OFFICE USE ONLY	
Date Received:	
Ref./File Number:	

Date: _____

I hereby apply for the benefit provided by the law governing the operation of the PARK EMPLOYEES' ANNUITY AND BENEFIT FUND, and in support of this application, I submit the following facts which I warrant to be true and correct.

1 Full Name: _____ _____ _____
(First) (Middle) (Last)

2. Address: _____

3. Social Security #: _____ 4. Tel. #: _____ 5. Email Ad: _____

6. Age at last birthday: _____ 7. Occupation: _____

8. On what date did accident happen? _____ Time: _____
Exact location (Name of Park or Beach, etc.) _____
Date CEASED WORK ENTIRELY: _____ Time: _____

9. What were you doing at the time? _____

10. What injury did you receive? Describe fully. _____
_____
_____

11. How long were you necessarily confined to your home after the injury? _____

12. On what date did you first see a physician? _____
Where did physician first attend you? _____
(your home, physician's office or elsewhere)

13. Name of Physician _____
Address _____

14. Dates of treatments: _____ ☐ Home ☐ Doctor's Office

15. Was any operation performed? ☐ YES ☐ NO If "YES", what kind? _____
When? _____ By whom? _____

16. Have you been confined to a hospital? ☐ YES ☐ NO If "YES", where? _____
Dates of confinement? From: _____ To: _____

17. Have you resumed work? ☐ YES ☐ NO If "YES", give date: _____

_____
Signature of Employee

Have you any MINOR children under 18 years of age? ☐ YES ☐ NO If 'YES', give below their names and dates of birth:

Name	Date of Birth

IMPORTANT: It is necessary that we have COPIES of their birth certificates in order that we may add a further benefit of $20.00 per month on each eligible minor child as prescribed in Section 12-140.

COMPLETED EITHER BY ATTENDING PHYSICIAN OR EMPLOYER APPROVED MEDICAL FACILITY

1 Name of employee: _____ Apparent age: _____

2. When did accident occur? _____ Time: _____

3. How did you understand it happened? _____

_____

_____

_____

4. When did you first examine and treat employee? _____

Where: _____

5. Had employee previously had medical attention? _____ If so, by whom? _____

6. What bodily injury was received? Describe fully: _____

_____

_____

7. What if any visible confusions or wounds did you find? _____

_____

8. What complications have arisen? _____

9. What operations if any, were performed? _____

When? _____ By whom? _____

10. State dates of treatment: _____ ❑ Home ❑ Doctor's Office

11. Have there been any laboratory tests made? If so, what are the results? _____

_____

_____

12. On what date was, or will patient be first able to resume his assigned duties in the park service, as described by him?

_____

13. Is the injury the sole cause of disability? _____ If not, what other ailments contributed to disability?

_____

_____

14. Additional comments from the attending physician: _____

_____

_____

I, a practicing physician, duly registered as such under the laws of the State of Illinois, my registry number being _____ do hereby certify that my answers to the foregoing questions are complete and true, to the best of my knowledge, information and belief.

_____

(Signature of Physician)

Date: _____ Address: _____

_____

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BENEFIT RECIPIENT FORM

Note: This form, completed and signed, must be filed with the Park Employees' Annuity and Benefit Fund before any benefits will be paid for Ordinary Disability (Sick Benefit) or Duty Disability (Injury on Duty).

Applicant's signature (***read before signing***): _____ Date: _____

Address: _____

Phone: ( ) _____ Zip Code: _____

I, _____ do hereby state that I am eligible for disability benefits
(applicant's printed name)
from the Park Employees' Annuity and Benefit Fund.

CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ My disability, injury, illness, etc. **is not** work related

☐ My disability, injury, illness, etc. **is** work related

The cause of my disability, injury or illness, etc. is: _____

_____

_____

_____

I state that I am or was working for the following company, companies or entities during the last 365 days: (Include self employment. Also list the Chicago Park District).

Company: _____ Address: _____
City: _____ Phone: _____
Amount Earned: _____ Last day of employment: _____

Company: _____ Address: _____
City: _____ Phone: _____
Amount Earned: _____ Last day of employment: _____

Company: _____ Address: _____
City: _____ Phone: _____
Amount Earned: _____ Last day of employment: _____

BENEFIT RECIPIENT FORM

I further state that I have applied or may be qualified to receive benefits for this disability from the following company or companies. (List the Chicago Park District if application is or will be made.)

Company: _____ Address: _____

City: _____ Phone: _____

Position: _____ Date Disability Payments began: _____

Company: _____ Address: _____

City: _____ Phone: _____

Position: _____ Date Disability Payments began: _____

(If more space is needed for this section, use the space provided below.)

I further state that I am receiving income from sources other than the Chicago Park District as follows:

_____

_____

_____

_____

Outside from the above, I am receiving income from no other sources.

I further state that I have or intend to file a Workmen's Compensation or Occupational Disease claim for this disability, injury or illness against: (List the Chicago Park District, if you have or intend to file a claim against it.)

Company's Name: _____

Address: _____

Company's Name: _____

Address: _____