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 without pay.**

If you were carried "S", that is, sick without pay, for 8 consecutive days or more and wish to receive Ordinary Disability, you must properly file the enclosed Application and Benefit Recipient Form. **(NOTE: NO BENEFIT IS PAYABLE FOR ABSENCES OF LESS THAN 8 CONSECUTIVE DAYS).**

In order to qualify for Ordinary Disability, an employee must be under the constant care of a competent physician; otherwise, no benefit will be paid. Please complete and sign Page 1 of 2 of the Application for Duty Disability Benefit and have your doctor complete and sign Page 2 of 2 of the same application form. Also complete the Benefit Recipient Form (2 pages). Return them to us in the enclosed stamped envelope.

It is important that the application be returned promptly so that the Board may have a medical report from its own doctor during your period of illness. **IN ADDITION, AN APPLICATION FOR ORDINARY DISABILITY MUST BE FILED WITHIN 60 DAYS FROM THE LAST DAY YOU WERE IN PAY STATUS.** Should there be any delay in filing your application, the payments cannot be backdated more than 60 days from the date you file the application.

If you were carried "S" for a minimum of **8 CONSECUTIVE DAYS IN THE PRECEDING MONTH AND HAVE PROPERLY FILED YOUR APPLICATION AND BENEFIT RECIPIENT FORM,** your claim will be presented to the Retirement Board at its next regular meeting scheduled for **THURSDAY, _____.** In order for action to be taken at this meeting, the forms must be in our office by _____.

Ordinary disability, that is, sick benefit is paid once a month on the third Thursday of the month for an absence of 8 consecutive days or more in the preceding month.

Sincerely,

Deanna Terranova
Claims Technician

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ORDINARY DISABILITY (MATERNITY)

PLEASE READ CAREFULLY!!!

ORDINARY DISABILITY (MATERNITY) BENEFIT COVERS 6 WEEKS FROM THE DATE OF BIRTH FOR A NORMAL DELIVERY AND 8 WEEKS FROM THE DATE OF BIRTH FOR A CESAREAN SECTION.

PLEASE NOTE THE FOLLOWING:

THE DISABILITY PERIOD WILL NOT EXTEND BEYOND THE PRESCRIBED 6 OR 8 WEEK PERIOD.

THE DISABILITY BENEFIT WILL BE REDUCED BY THE CHICAGO PARK DISTRICT BENEFIT TIME (i.e. vacation days, sick days, floating holidays) USED DURING THE ABOVE PERIODS.

IF YOU HAVE ANY FURTHER QUESTION OR HAVE ANY MEDICAL COMPLICATIONS, PLEASE CALL THE PENSION OFFICE IMMEDIATELY.

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APPLICATION for ORDINARY DISABILITY BENEFIT NON-JOB RELATED

Note: Return this form as soon as possible; Payment cannot be dated back more than 60 days from receipt of application.

Date: _____

I, _____
(Name of Employee) (Social Security No.) (Age)

residing at _____
(Address) City/State/Zip (Home Phone No.)

was taken ill on _____ and date when "S" time began _____
(Date) (Date)

and for the purpose of applying for benefits under the provisions of the law governing the operation of the PARK EMPLOYEES' ANNUITY AND BENEFIT FUND, submit herewith the answers to the following questions, which answers I hereby warrant to be true and correct.

1) When did you first see a physician for this illness? Date: _____
Where? (i.e. physician's office or elsewhere) _____

2) State physician's name: _____
Address & Phone Number: _____

3) What was your occupation when taken ill? Describe your usual duties. _____
_____
_____

4) What is the nature of the illness? Describe symptoms fully: Name part of body affected: _____
_____
_____

5) Were you hospitalized for this sickness? ❑ Yes ❑ No If YES, from _____ to _____
Name of Hospital: _____
Address: _____

6) When will you be able to return to work? _____

7) Have you had any medical or surgical treatment during the past five years? If so, detail briefly: _____
_____
_____

I HEREBY STATE THAT THIS CLAIM FOR ORDINARY DISABILITY SET FORTH IN THIS APPLICATION IS IN NO WAY CONNECTED WITH THE DUTIES ASSIGNED TO ME BY MY EMPLOYER, NAMELY THE CHICAGO PARK DISTRICT NOR DID IT ARISE OR OCCUR OUT OF MY EMPLOYMENT.

_____
(Signature of Employee)

REPORT OF ATTENDING PHYSICIAN

The examination of _____
(Patient's Name)

1) When and where did you FIRST examine the above employee for this illness?
Date: _____ Place: _____
(Patient's home, your office or elsewhere)

2) What is the exact nature of illness? Give complete diagnosis of case: _____
_____
_____
_____

3) If a disease, is it - - - Acute? ❑ Chronic? ❑ Venereal? ❑

4) What operation, if any, did you perform? _____

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

6) Are there any complications that may prolong disability? _____
_____
_____

7) When and where did you LAST attend upon and prescribe for claimant?
Date: _____ Place: _____

8) On what date will employee be able to resume his/her assigned duties in the park service?
Please specify: _____

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

_____
(Signature of Physician)

Date: _____ Address: _____

Note: Please return this form as soon as possible; benefit payment cannot be dated back more than 60 days.

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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: _____

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ORDINARY DISABILITY INCOME – "S" TIME – IS TAXABLE
(In lieu of Federal Form W4S)

If you wish us to withhold from your ordinary disability check, please complete this form and return it. If you do not want taxes withheld, please note that you are liable for any tax due through estimated tax payments.

Name (please print or type): _____ SSN: _____

Present legal address: _____
Street Apt. #

_____
City /State Zip Code

I REQUEST VOLUNTARY INCOME TAX WITHHOLDING FROM MY BENEFIT PAYMENTS AS AUTHORIZED UNDER THE INCOME TAX LAW.

(Enter the amount of Federal Income Tax to be withheld from each payment on the line below).
Note: IT CANNOT BE LESS THAN $88.00 PER MONTH.

$ _____

Signature of Employee: _____ Date: _____

RETURN TO: PARK EMPLOYEES' ANNUITY AND BENEFIT FUND
55 EAST MONROE STREET, SUITE 2720
CHICAGO, Illinois 60603

CUT ALONG THIS LINE – PLEASE KEEP THIS PORTION FOR YOUR RECORDS

TO BE KEPT BY THE BENEFIT RECIPIENT

Under the Income Tax Regulations, the minimum amount of Federal Income Tax that can be withheld is $22.00 per week ($88.00 per month). The amount to be withheld must be stated on a monthly basis. If you are off less than a month, the amount will be prorated. The minimum amount of sick pay remaining after withholding must be at least $10.00.

Requested Federal Withholding Tax from each disability payment $_____.

Dated: _____