|  |  |
| --- | --- |
| Name of Applicant |  |
| Date of Hire |  |
| Job Title |  |

1. Provide detailed information regarding the incident, including information relating to how the injury was sustained in the line of duty (date, time, place, nature of injury, and other factual circumstances surrounding the incident giving rise to said claim). Attach additional sheets as necessary.
2. Describe whether the catastrophic injury or death occurred as a result of (indicate which applies and provide details; attach additional sheet if necessary):

a) the officer’s response to fresh pursuit;

b) the officer or firefighter’s response to what was reasonably believed to be an

emergency;

c) an unlawful act perpetrated by another; or

d) during the investigation of a criminal act.

1. List all witnesses (including addresses and other contact information) to the catastrophic injury or death (attach additional list if necessary); if no witnesses, indicate as such:
2. List all witnesses (including addresses and other contact information) the Applicant intends to call at the PSEBA hearing; if no witnesses, indicate as such:
3. Provide any other facts that would qualify you for possible benefits under the Act (attach additional sheet if necessary):
4. Has the applicant previously applied for and been denied benefits under the Act?

Yes **(if yes, attach copy of application and denial)**

No

Attach information (including supporting documentation) relating to your pension claim.

1. List all current sources of health insurance benefits available to you. Include company name and benefit plan (including City health insurance plan, if currently enrolled).
2. Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Source: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employee Certification**

I, (print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby make application for benefits under the Public Safety Employee Benefits Act (Act). The information contained herein is true, correct, accurate, and complete to the best of my knowledge and belief. I understand that it is unlawful for a person to willfully and knowingly make, or cause to be made, or to assist, conspire with, or urge another to make, or cause to be made, any false, fraudulent, or misleading oral or written statement to obtain health insurance coverage as provided under the Act. Such actions constitute a Class A misdemeanor. I further understand that if convicted of a violation under this Act, I / my beneficiaries forfeit the right to receive health insurance benefits and shall reimburse The City of Lake Forest for all benefits paid due to the fraud or other prohibited activity. I agree to cooperate fully in any fact-finding the City deems necessary or appropriate in evaluating my eligibility for benefits under the Act, and I understand that my refusal to so cooperate shall result in my application being deemed withdrawn and waived.

*Signature of Applicant:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribed and Sworn to before me this \_\_\_\_\_\_\_Day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (SEAL)

Notary Public

I, (print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize my physicians, psychologists, psychiatrists, counselors, physical therapists, medical facilities, hospitals, clinics, labs, and any other health care providers, as well as the institution(s) with which they are affiliated, to release to The City of Lake Forest and/or its representatives any medical records, mental health information or other medical information (including but not limited to my entire medical file, any spoken, written, photographic or electronic records or facts about my medication reports, consultation reports, billing records, payment records, medical or mental health condition, reports, treatment records, x-rays, photographs, studies, notes, payments, prescriptions, insurance records or claims forms) which relate in any way to the injury to my \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (part of body) derived from medical and/or mental health services provided by the following health care providers and medical facilities (hospitals, laboratories, etc.):

|  |  |  |
| --- | --- | --- |
| Name | Address | Telephone |
|  |  |  |
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The above-described medical records and information should be released to The City of Lake Forest, Attn: Director of Human Resources, 800 N. Field Drive, Lake Forest, IL 60045 or any other authorized City representative. I know that these records will be used for legal matters connected with my application for benefits under the Public Safety Employee Benefits Act and that my records may be disclosed to consultants, experts and legal counsel hired by the City.

This request specifically includes the release of any records relating to my current or past mental health status as deemed relevant by The City of Lake Forest, so that the City may assess my qualification for benefits under the Public Safety Employee Benefits Act. I understand that by releasing these records, I am waiving any rights I might have under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, which governs.

I know that my records may also contain other very private information about sexually transmissible diseases (such as hepatitis, syphilis, or gonorrhea), human immune deficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) tests and results. If so, I allow the sharing of this information, including the HIV or AIDS test results, with the City. I give up and waive the protections under Federal and State Laws.

This consent will expire one year from the date signed, unless I revoke it earlier, in writing, and signed by a witness who can attest to my identity. I understand any such revocation will not be effective until delivered to the health care providers listed above and will not affect any prior release of information. I understand I may ask to inspect and/or copy the records that are being released.

I know that signing this form is voluntary and waives certain rights I have under the Health Insurance Portability and Accountability Act (HIPAA). If I do not sign this form, it will not affect how my health care providers treat me or my enrollment in a health plan.

I agree that a copy of this form may be treated as a signed original.

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Employee Date

or Employee’s Authorized Representative

Subscribed and Sworn to before me this \_\_\_\_\_\_\_Day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (SEAL)

Notary PublicI, (print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize The City of Lake Forest’s workers compensation carrier; the Board of Fire and Police Commissioners; the Police Pension Board; the Fire Pension Board; the PSEBA Administrative Hearing Officer and any other person or entity to release to The City of Lake Forest and/or its representatives any records which relate in any way to the injury to my \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (part of body) pursuant to which my claim for benefits under the Public Safety Employee Benefits Act is made. The above-described records and information should be released to The City of Lake Forest, Attn: Human Resources Department, 800 N. Field Drive, Lake Forest, IL 60045 or any other authorized City representative.

This request specifically includes the release of any records The City of Lake Forest reasonably deems relevant to assess my qualification for benefits under the Public Safety Employee Benefits Act. This consent will expire one year from the date signed, unless I give written notice of earlier revocation to The City of Lake Forest, Attn: Director of Human Resources, 800 N. Field Drive, Lake Forest, IL 60045 or any other authorized City representative. I understand that any such revocation will not be effective until delivered to The City of Lake Forest and will not affect any prior release of information. I understand that I may ask to inspect and/or copy the records that are being released.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Employee Date

or Employee’s Authorized Representative

Subscribed and Sworn to before me this \_\_\_\_\_\_\_Day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (SEAL)

Notary Public