

CITY OF FORT LAUDERDALE GENERAL EMPLOYEES' RETIREMENT SYSTEM

APPLICATION FOR DISABILITY BENEFITS

I realize by submitting this application for Disability Benefits to the Board of Trustees that, if approved, under current Union Agreements, I will forfeit my seniority and will be terminated as an employee of the City.

Type of Disability you are applying for: On-the-Job Off-the-Job

Type or Print

Name _____ Soc Sec No. _____

Home Address _____

City, State _____ Zip _____

Phone No. _____ E-Mail Address _____

Department _____ Timekeeper _____

Date of Injury/Illness _____ Last Date Worked _____

Describe the nature of the disabling Injury or Illness _____

Signature _____ Date _____

List below the information of **TWO OR MORE** medical doctors who have treated you regarding your disabling condition **WITHIN THE PAST THREE MONTHS:**

Doctor 1: _____ Date last seen: _____

Field or Specialty: _____

Address: _____

City, State, Zip _____

Phone No. _____ Fax No. _____

Doctor 2: _____ Date last seen: _____

Field or Specialty: _____

Address: _____

City, State, Zip _____

Phone No. _____ Fax No. _____

Doctor 3: _____ Date last seen: _____

Field or Specialty: _____

Address: _____

City, State, Zip _____

Phone No. _____ Fax No. _____

Doctor 4: _____ Date last seen: _____

Field or Specialty: _____

Address: _____

City, State, Zip _____

Phone No. _____ Fax No. _____