

APPLICATION FOR DISABILITY

Department of State Treasurer, Firemen's and Rescue Squad Workers' Pension Fund
325 North Salisbury Street, Raleigh, North Carolina 27603-1385

Name _____ S.S. No. _____
Address _____ Date of Birth _____
City _____ State _____ Zip _____ Code _____ Telephone (____) _____
Fire ☐ Rescue ☐ Department Name _____

DISABILITY INFORMATION:

1. Date of disability _____
2. Indicate principal cause of disability _____
3. Was disability the result of a line of duty injury? YES _____ NO _____ If yes, describe how the injury occurred. _____

Are you a member of the Local Governmental Employees' Retirement System or Teachers' and State Employees' Retirement System? YES _____ NO _____ If yes, have you applied or been approved for disability benefits under either the Local System or State System? YES _____ NO _____ If yes, it will not be necessary for the Medical Report Form 7B to be completed. Otherwise, Form 7B must be completed by your physician before your application can be given consideration by the Medical Board.

MEMBER CERTIFICATION:

I hereby certify that the above information is true and correct to the best of my knowledge under penalty of law.

Signature _____ Date _____

DEPARTMENT CERTIFICATION:

I hereby certify that the information on the above-named person is true and correct to the best of my knowledge under penalty of law.

Authorized Signature _____ Title _____

Telephone No. (____) _____ Date _____