Disability Benefit Application Packet

This checklist will aid in your application for a disability benefit from The General Retirement System for Employees of Jefferson County. Disability benefits are available to certain eligible Members of The General Retirement System for Employees of Jefferson County ("GRS"). A Member is eligible for disability benefits if he or she has either a Total Disability or a Partial Disability. A "Total Disability" means a permanent physical or mental condition of a Member resulting from bodily injury, disease, or mental disorder which renders such Member incapable of continuing usual and customary employment with Jefferson County (the "County"). A "Partial Disability" means a permanent disability that is less than a Total Disability.

Additionally, eligibility and benefits differ based on whether a disability is service-connected or not. Service Connected Disability Benefits are available to Members that are disabled in the course of their employment with the County. Non-Service Connected Disability Benefits are available to vested Members who are disabled while employed by the County, but are not disabled in the course of their employment. **You must complete the application process BEFORE leaving employment.**

- ☐ As soon as you become disabled, apply for ADA reasonable accommodation.
  - For Jefferson County Commission employees contact FMLASource via one of the following methods:
    - www.fmlasource.com
    - Mobile App "FMLASource Now" for Google Play or Apple iOS
    - Email FMLACenter@fmlasource.com
    - Phone: (888) 789-3994
  - For Jefferson County Sheriff's employees contact Internal Affairs at (205) 325-5709.

  You are only eligible to apply for a disability benefit if you are denied a reasonable accommodation.
- ☐ Obtain a letter from your personal physician stating what your disability is and whether or not he/she feels that it is a permanent disability.
- ☐ Complete the Application for Disability Benefit.
  - This form must be notarized.
- ☐ Complete the HIPAA Authorization.
  - This form must be notarized.
- ☐ Complete the UAB Medical Release Form.
  - Only complete highlighted questions.

The application process is not complete until you have returned the letter from your personal physician, application for disability benefit, HIPAA Authorization, and UAB Medical Release Form. GRS will confirm the denial of a reasonable accommodation with Jefferson County Human Resources.

THE GENERAL RETIREMENT SYSTEM FOR EMPLOYEES OF JEFFERSON COUNTY

APPLICATION FOR DISABILITY BENEFIT

I, _____ (Name of Member), hereby apply for a disability benefit on

(Please type or print name)

account of either partial or total disability under the provisions of The General Retirement System For Employees of Jefferson County ("GRS").

You must return this completed Application to the General Retirement System no later than the date of your termination of employment in order to be considered for a disability benefit.

☐ I requested and was denied a reasonable accommodation from my employer.

I am applying for a ☐ service-connected and/or ☐ non-service connected disability benefit for the following reasons:

_____

_____

Date my incapacitation from duty started _____

My personal physician is _____

Physician's Address _____

Physician's Phone Number _____

I hereby authorize my personal physician to make a report regarding my condition to the Pension Board and/or to the physician or physicians designated by the Board. I understand that I also must complete and have notarized the HIPAA Authorization for Disclosure of Protected Health Information form ("HIPAA Authorization") and the UAB Medical Release form.

I hereby authorize the Pension Board to conduct verification checks with any third parties including past, present, and future employers, physicians, nurses, hospitals, neighbors and credit reporting agencies of matters asserted by me or on my behalf regarding this application and subsequent status reviews of any disability awarded by said Board.

I understand that if I accept a disability benefit, (i) such benefit will be paid in lieu of any other benefit otherwise payable under the plan; (ii) I will not be able to elect a Joint Survivorship Pension, and I understand the difference between a disability benefit election and a Joint Survivorship Pension election; (iii) payment of a disability benefit will only continue as long as I remain permanently disabled, and (iv) no payments will be made upon my death, unless the total of disability benefit payments made to me is less than the amount of contributions that I made to GRS, in which case the difference between my contributions and the disability benefit payments will be paid to my designated beneficiary as a refund.

Return this completed form, the completed HIPAA Authorization and UAB Medical Release form to:

General Retirement System
Suite 430 Courthouse
716 Richard Arrington Jr. Blvd. North
Birmingham, Al 35203

We cannot proceed with your disability request until we have received these forms (no later than the date of your termination of employment) and also received a letter from your personal physician. Questions can be directed to the address above or you can call (205) 784-4530.

[Execution Page Follows]

EXECUTION

_____
Signature of Member

_____
Date of Birth of Member

_____
Telephone/Mobile Number of Member

_____
Social Security Number of Member

_____
Street Address of Member (No P.O. Box)

_____
City, State and Zip Code of Member

_____
Date

[You must have this application notarized below.]

_____

STATE OF _____)

_____ **COUNTY**)

I, the undersigned authority, a Notary Public in and for said County in said State, hereby certify that _____, whose name is signed to the foregoing Application for Disability Pension, and who is known to me, acknowledged before me on this day that, being informed of the contents of said instrument, he or she executed the same voluntarily on the day the same bears date.

Given under my hand and official seal this the _____ day of _____, 20_____.

_____
Notary Public Signature

[NOTARIAL SEAL]

_____
Notary Public Printed Name

My commission expires: _____

Return this completed form to:

General Retirement System
Suite 430 Courthouse
716 Richard Arrington Jr. Blvd. North
Birmingham, Al 35203

Questions can be directed to the address above or you can call (205) 784-4530.

THE GENERAL RETIREMENT SYSTEM FOR EMPLOYEES OF JEFFERSON COUNTY

HIPAA AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____(Name of Member), hereby authorize the disclosure of my Protected Health Information (as defined below) to The General Retirement System for Employees of Jefferson County, its employees, agents and designees (collectively, "GRS"), which shall include the following: the Pension Board, the General Retirement System staff, GRS attorneys, and all other person(s) determined by the Pension Board or General Retirement System to be necessary to assist in the review of my Application for Disability Pension and the continuing status of my disability over time.

The Protected Health Information to be disclosed and covered by this authorization is in connection with my Application for Disability Pension and any subsequent reviews of my disability in the future. Such information may consist of any and all of my health information, including, but not limited to, physicians' records, progress notes, consultations, prescriptions, physicals and histories, health insurance information in my medical file related to my disability, correspondence, diagnosis or other information pertaining to my disability (collectively, "Protected Health Information").

I authorize the following physician(s) and/or organization(s) to disclose my Protected Health Information to those individuals at GRS who are responsible for administration of my pension disability benefits (hereinafter referred to as "Authorized Persons"):

(a) Treating Physician: _____

(b) Other Physicians or Organizations Responsible for Treatment of illness or diagnosis pertaining to your disability (*e.g.*, a home health agency or rehabilitation hospital):

_____

_____

(c) Pension Board Medical Advisor: University of Alabama at Birmingham

The disclosure of Protected Health Information pursuant to this authorization will be limited to those purposes necessary for administration of my disability pension benefits.

I understand that I may revoke this authorization in writing at any time, except to the extent that the Authorized Persons have taken action in reliance on this authorization before receiving written notice of my notification to revoke. This authorization expires upon the discontinuance of my disability pension, or upon the rejection or denial of my Application for Disability Pension, if not sooner revoked by me.

I understand that this authorization is voluntary and it is being made at my direction. I understand that I have a right to refuse to sign this authorization. I understand that this authorization will not impact treatment of my condition or payment or eligibility for my health insurance benefits. However, I understand that such authorization is necessary for the processing of my Application for Disability Pension and administration of my disability pension benefits.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction, and that a photocopy of this document is as valid as the original to allow the release and disclosure of my Protected Health Information as set forth above.

_____
Signature

_____
Telephone/Mobile Number

_____
Social Security Number

_____
Street Address (No P.O. Box)

_____
City, State and Zip Code

_____
Date

[Your authorization must be notarized below.]

STATE OF _____)
_____ COUNTY)

I, the undersigned authority, a Notary Public in and for said County in said State, hereby certify that _____, whose name is signed to the foregoing HIPAA Authorization for Disclosure of Protected Health Information, and who is known to me, acknowledged before me on this day that, being informed of the contents of said instrument, he or she executed the same voluntarily on the day the same bears date.

Given under my hand and official seal this the _____ day of _____, 20_____.

_____
Notary Public Signature

[NOTARIAL SEAL]

_____
Notary Public Printed Name

My commission expires: _____

Return this completed form to:

General Retirement System
Suite 430 Courthouse
716 Richard Arrington Jr. Blvd. North
Birmingham, Al 35203

Questions can be directed to the address above or you can call (205) 784-4530.

UAB MEDICINE

Patient Request for Own Medical Records

UAB Medicine recognizes a patient's right to access their own protected health information.

Patient Information (please print)

Patient Name: _____ Patient Birthdate: _____ /_____ /_____

Patient Street/Mailing Address: _____

City, State, and Zip: _____ Patient Phone: _____

UAB Medicine should provide records to ☐ me for my personal use or to ☐ the party indicated below:

Name of person/organization receiving my information: _____

Street address: _____ City: _____ State: ____ Zip: _____

Are you requesting psychiatric or substance use records to be included in the release? ☐ Yes ☐ No

Date range for records: From _____ to _____ OR specific date: _____

(**If no date is listed, records for the past 12 months will be provided.)**

☐ **If your records are going to another provider, please check here and they will be provided with the continuity of care/treatment package.** (Includes key clinical notes, medication list, and histories)

Select the record package that best meets your need for this request:

☐ Package 1 - Key Clinical Notes: Current history and physical, discharge summary, operative reports, outpatient clinic notes, Emergency Department provider documentation

☐ Package 2 - Clinical Notes: Package 1 plus medication list

☐ Package 3 – Clinical Notes II: Packages 1 and 2 plus diagnostic reports and laboratory test results

☐ Package 4 – Laboratory test results, Radiology reports, and other diagnostic reports

☐ Package 5 - Entire Medical Record: Package 3 plus nursing documentation. Excludes Fetal Monitoring strips- if needed, please select below.

If you selected Package 1, 2, 3, 4, or 5 above, the following documentation, except billing records, fetal monitoring strips, and Radiology images, will be included in your selected package. However, if your request is specifically for any of the following only, please check the appropriate box(es):

☐ Operative/Procedure Report(s) ☐ Emergency Department Documentation

☐ Discharge Summary ☐ Outpatient Clinic Notes ☐ Billing Records ☐ Medication List

☐ Fetal Monitoring Strips

☐ Radiology Images: Please specify images needed: _____

☐ Other specific record needed: _____

UAB MEDICINE

Patient Request for Own Medical Records

Records Delivery (select one)

☐ **Paper**:

- ☐ Mailed to address on this Authorization.
- ☐ Pick up by _____

☐ **Electronic:**

- ☐ Faxed to number: _____
- ☐ CD (mailed only to address on this Authorization)
- ☐ Email to address: _____

NOTICE: If I request records in electronic form, I understand that the records will be encrypted to help protect my privacy and the security of my health records and that I will be furnished with the information on how to access those encrypted records. UAB Medicine is not responsible for the privacy and security of the electronic records on the CD or in an email once they are received by the intended recipient.

I hereby request/authorize the use or disclosure of my protected health information ("PHI") as described above. This request includes any information relating to drug, alcohol use/treatment, communications with psychiatrists or psychologists, and records pertaining to sexually transmitted diseases, if they are a part of my medical record.

Once this information has been disclosed, it may be subject to re-disclosure and no longer protected by federal regulations.

Signature of patient or personal representative: _____

Printed name of patient: _____

Printed name of personal representative: _____

Relationship to the patient: _____ Date: _____

Return Completed Form:
UAB Health Information Management
Release of Information Office
1201 11th Ave. South
Birmingham, AL 35205
Fax: 205-930-6721