ORLAND FIRE PROTECTION DISTRICT
APPLICATION FOR BENEFITS
UNDER THE PUBLIC SAFETY EMPLOYEE BENEFITS ACT

Name of Applicant: ____

Date of Application: ____

If applicant is a family member,
indicate relationship to injured/
deceased employee: ____

Date of hire of the injured/
deceased employee: ____

Job title of injured/deceased
employee: ____

Please describe the catastrophic injury or death that occurred in the line of duty, including the exact date of the injury or death (attach additional documentation if necessary):

____

____

____

____

____

____

Did the injury or death occur as the result of the firefighter's response to what is reasonably believed to be an emergency, an unlawful act perpetrated by another, or during the investigation of a criminal act? Yes [ ] No [ ]

If yes, please explain: ____

____

Has a line-of-duty disability pension or other pension been applied for or granted by the Fire Pension Fund Board: Yes [ ] No [ ]

Please indicate the type of pension disability benefits awarded for this injury:

line-of-duty [ ] occupational disease [ ] not in duty [ ] survivor benefits [ ]

Date of application for pension benefits: ______________________________

Date of award of pension benefits: ____________ Or Date pension denied: ____________

Applicant is responsible for submitting a copy of all materials submitted in support of pension application and any decision from the Pension Fund Board.

If requested by the District, applicant is responsible for submitting a copy of all transcripts and exhibits from a Pension Board hearing that resulted in the award of a duty-related disability pension.

Has the applicant or employee (if different than applicant) previously applied for and been denied benefits under the Act? Yes [ ] (if yes, please attach copy of application and denial) No [ ]

Please indicate for whom you are claiming health insurance benefits: employee [ ] spouse [ ] dependent children [ ]

List all witnesses to the catastrophic injury or death (attached additional list if necessary): if no witnesses, indicate as such:

1) Name: ______________________________

2) Name: ______________________________

3) Name: ______________________________

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 firefighters fresh pursuit,

____ b) the firefighter's response to what is reasonably believed to be an emergency,

____ c) an unlawful act perpetrated by another, or

____ d) during the investigation of a criminal act.

____

____

____

____

Has the applicant experienced prior injuries to the same part of the body affected by the catastrophic injury? If yes, please describe those injuries (attached additional sheet if necessary).

____

____

____

Provide any other facts that would qualify you for possible benefits under the Act (attached additional sheet if necessary):

____

____

____

____

____

____

If you are claiming health insurance benefits for a spouse or dependent children, please indicate their names, dates of birth, and Social Security numbers:

Name	Date of Birth	Social Security Number

Name of current employer: ____

Address: ______________________________ Phone No.: ______________________

Name of spouse's current employer: ______________________________________

Address: ______________________________ Phone No.: ______________________

Section 10(a)(1) of the Public Safety Employee Benefits Act (820 ILCS 320/10 (a)(1)) provides that health insurance benefits payable from any other source shall reduce benefits payable under this Act. Please indicate any other source of health insurance benefits for you, your spouse or children. (Including Medicare). Please include the name of the employer (if applicable), name of the health insurance plan, plan and/or group number, the name of contact person who administers this plan, and any applicable phone numbers. Please attach a copy of the applicable insurance card:

1) Source:____
2) Source:____
3) Source:____

If reimbursement of premiums is sought, attach proof of coverage and proof of past premium payments.

____

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, and accurate 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. A violation of this item is 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 Orland Fire Protection District for all benefits paid due to the false, fraudulent, or misleading statements or other prohibited activity. I agree to cooperate fully in any fact-finding the District 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.

______________________________	______________________________
Applicant (Signature)	Social Security Number
______________________________	______________________________
Print Name	Address
______________________________	______________________________
Date	Phone Number

Subscribed and Sworn to before me this _______ Day of ___________________, 20___.

____
Notary Public

I, (print name)______________________________hereby authorize my physicians, psychologists, psychiatrists, counselors, physical therapists, medical facilities, hospital, clinics, labs and any other health care providers, as well as the institution(s) with which they are affiliated, and all insurers who paid claims for my treatment related to my injury, to release to the Village of Bolingbrook and/or its representative 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

The above-described medical records and information should be released to the Orland Fire Protection District, ATTN: Human Resources Department, 9790 W. 151st Street, Orland Park, IL 60462. 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 District.

This consent will expire one (1) year from the date signed, or, if PSEBA benefits are awarded, upon the cessation of those benefits, unless I revoke it earlier, in writing, and signed by a witness who can attest to your 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 agree that a copy of this form may be treated as a signed original.

Social Security #: _____________________

Date of Birth: ________________________

____ ________________________
Signature of Applicant Date

Subscribed and Sworn to before me this ____Day of ___________________

____
Notary Public

I, (print Name) ____________________________________hereby authorize Orland Fire Protection District's workers compensation carrier, the Board of Fire Commissioners; the Fire Pension Board; and any other person or entity to release to the Orland Fire Protection District 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 Orland Fire Protection District, Attn: Human Resources Department, 9790 West 151st St., Orland Park, IL 60462, or any authorized representative.

This request specifically includes the release of any records the Orland Fire Protection District reasonably deems relevant to assess my eligibility for benefits under the Public Safety Employee Benefits Act. This consent will continue and expire one (1) year from the date signed, or, if PSEBA benefits are awarded, upon the cessation of those benefits, unless I give written notice of earlier revocation to the Orland Fire Protection District, Attn: Human Resources Department, 9790 West 151st St., Orland Park, IL 60462, or any authorized representative. I understand that I may ask to inspect and/or copy the records that are being released.

____________________________________ __________________

Signature of Applicant Date

Subscribed and Sworn to before me this _____day of _____________________, ________

__________________________________(Seal)

Notary Public