



Luzerne County Employees' Retirement System Attending Physician's Statement

Every question **MUST** be distinctly and fully answered by the attending physician.

1. Name of Patient:
2. Residence of Patient:
3. Age:
4. How long have you personally known this patient?
5. Date of first visit, consultation or prescription for the illness or accident resulting in the present condition.
6. What organ, systems or part of the body has been attacked or injured?
7. Describe the course of the disease and history of its progress, or the manner in which the member was injured.
8. What pathological changes have occurred and in your opinion are they permanent?
9. Is the member totally and permanently incapacitated from performing the duties of a county employee? If so, what is the manner in which the member is incapacitated?

10. Is this disability likely to increase? If not, what is the prognosis?
11. State fully all ailments for which you have previously attended the member with dates and duration of illness, in their consecutive order. Was recovery complete in each case?
12. Give names and addresses of each and every physician who prescribed for or was consulted by the member.
13. When and where did you receive your medical diploma?
14. Please list your complete office address
15. Please list your office phone number with area code

I do hereby affirm that I have carefully read the above questions and have written the answers thereto; that each and every one of the said answers are full, complete and true to the best of my knowledge and belief; and that there are no material facts in the case which are not disclosed.

Signature of Attending Physician

Date

Print Name of Attending Physician

**Completed form should be sent to: Richard Hummer, Pension Coordinator,
20 N. Pennsylvania Ave.
Wilkes-Barre, PA 18701**



Luzerne County Employees' Retirement System

Application for Disability Retirement Allowance

In accordance with the County Pension Law, Act No. 96 of 1971 as amended, I hereby apply for a Disability Retirement Allowance.

Member Name	Member SS#	Emp#	Home Phone
Address	Date of Birth	Date of Hire	
City, State, Zip	Department Name and No.		Department Phone No.
Position Held			

Describe in full your present condition and state below how and to what extent you are incapacitated from performing your duties as a county employee.

Date when Disability allowance is to become effective: _____

Attending Physician Information:

Name: _____ Phone: _____
 Address: _____ Fax: _____

It is understood and agreed that the Disability Retirement is equal to 25 percent of my Final Average Salary and that all Disability Retirement Allowance payments cease at my death, except that if I die before receiving aggregate payments equal to my Accumulated Deductions at the time of my retirement, the difference shall be paid to my estate or designated beneficiaries as follows:

Name: _____ Relationship: _____ Share: _____
 Address: _____ Date of Birth: _____ Primary/Contingent
 Social Security: _____

Name: _____ Relationship: _____ Share: _____
 Address: _____ Date of Birth: _____ Primary/Contingent
 Social Security: _____

(Continued)

Luzerne County Employees' Retirement System

Application for Disability Retirement Allowance (continued)

SIGNATURE MUST BE WITNESSED BY A NOTARY PUBLIC

The execution of this designation of beneficiary revokes all prior designations that I have made. I declare the factors to be true to the best of my knowledge and belief.

Signed and sworn before me on this _____ day of _____, 20_____.

Notary Public: _____

MEMBER SIGNATURE

Member Name (Print)

Social Security Number

Signature of Member

Date Signed

Completed form should be sent to: Richard Hummer, Luzerne County Pension Coordinator
20 N. Pennsylvania Ave
Wilkes-Barre, PA 18701



Luzerne County Employees' Retirement System Application for Disability Retirement Allowance

In accordance with the County Pension Law, Act No. 96 of 1971 as amended, I hereby apply for a Disability Retirement Allowance.

It is understood and agreed that the Disability Retirement benefit is equal to 25 percent of my final average salary and that all Disability Retirement Allowance payments cease at my death, except that if I die before receiving aggregate payments equal to my Accumulated Deductions at the time of my retirement, the difference shall be paid to my estate or designated beneficiaries as follows:

Name: _____ Relationship: _____ Share: _____
Address: _____ Date of Birth: _____ Primary/Contingent
Social Security: _____

Name: _____ Relationship: _____ Share: _____
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Social Security: _____

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Social Security: _____

Name: _____ Relationship: _____ Share: _____
Address: _____ Date of Birth: _____ Primary/Contingent
Social Security: _____

SIGNATURE MUST BE WITNESSED BY A NOTARY PUBLIC

The execution of this designation of beneficiary revokes all prior designations that I have made. I declare the factors to be true to the best of my knowledge and belief.

Signed and sworn before me on this _____ day of _____, 20_____.

Notary Public: _____

MEMBER SIGNATURE

Member Name (Print) _____

Social Security Number _____

Signature of Member _____

Date Signed _____

Completed form should be sent to: **Richard Hummer**
Luzerne County Pension Coordinator
20 N. Pennsylvania Ave.
Wilkes-Barre, PA 18701