Ohio Police & Fire Pension Fund
140 East Town Street
Columbus, OH 43215
Phone: 1–888–864–8363
Fax: (614) 628–1777
www.op–f.org

DISABILITY RECONSIDERATION APPLICATION
and earned income statement

If you are currently receiving a less than maximum partial disability benefit from the Ohio Police & Fire Pension Fund (OP&F) and your earnings capacity has become further impaired through a deterioration of the disabling condition(s) for which you were placed on disability retirement, then you are eligible to apply for a reconsideration of your current grant. To do so, you must:

1: complete this application;
2: submit new medical evidence which substantiates your claim of increased disability.

To avoid a possible delay in processing your application, please be certain to complete all sections of this form, even if some areas are not applicable. Once the OP&F Board of Trustees' Disability Committee has reviewed these documents, it may decide that further evidence is required, order a re-examination by a physician appointed by OP&F, or render a decision to increase, decrease or to leave the initial grant unchanged.

Section A: Member information

Name: First, MI, Last, suffix (Jr. III, etc.)

Street Address / Post office box

City, State, ZIP code

Home phone:

Alternative phone:

Social Security Number

Date of Birth

Date of Retirement

Section B: Disabling Medical Condition(s)

Part 1: List all medical and/or psychological conditions considered upon initial application or appeal (i.e. Left Knee injury):

Disability	**Date of Onset**	**Cause** (if known)
1:		
2:		
3:		
4:		

Part 2: Name the condition(s) **that have worsened since your initial application or appeal:**

Disability	**Date of Onset**	**Cause** (if known)
1:		
2:		
3:		
4:		

Section C: Training Program

Have you tried to enroll in any training or apprenticeship program(s)? ❑ yes ❑ no

If yes, indicate the training program(s) in which you had enrolled as well as whether or not it was successfully completed:

Program name: Successfully completed? ❑ yes ❑ no

Are you receiving Worker's Compensation? ❑ yes ❑ no

If yes, what benefits are you currently receiving:

❑ Medical expenses ❑ Temporary total ❑ Temporary partial ❑ Permanent total ❑ Permanent partial

Are you receiving Social Security disability payments? ❑ yes ❑ no

Section D: Earned Income Report

Please state your earned income (wages, self-employed compensation, tips) in each complete tax (calendar) year since you retired. If you have been retired for more than five years, report only your earned income for the last five complete years. Also report your primary employer, job title and the duties performed.

Year	**Earned Income***	**Employer** (list only primary employer)	**Job Title**	**Duties Performed**
20	**$**			
20	**$**			
20	**$**			
20	**$**			
20	**$**			

** Do not report spouse's income, interest, dividends or income from sources other than wages, self-employed compensation, tips, etc.*

Section E: Member signature and acknowledgement

I, the member described in Section A of this Disability Reconsideration Application, represent that I am the person herein described; it is my will and intent to apply for a reconsideration of disability benefits under Chapter 742 of the Ohio Revised Code; I understand that this application will not be processed until received by OP&F, and determination of my eligibility to file this application has been determined by OP&F; and that the statements made herein are true and correct.

I certify, under penalties of perjury, that I have reviewed this OP&F application for disability benefits and all statements and documents supporting my application are truthful and accurate. I understand that if the statements and/or documents supporting the application are proven to be false it may result in the termination of any benefits that may be payable to me, as well as possible civil and criminal penalties.

Member's signature: ▶	Date of signature:

Section F: Notary public requirement

The notary public in good standing must sign in the space provided in this section and affix their seal.

State of _____, County of _____, ss:

The foregoing *Disability Reconsideration Application* was acknowledged before me by the member named in the foregoing Section A, this _____ day of _____ , 20_____.

Affix Seal here	Notary's signature: ▶
	Print name:
	My commission expires: