



OP&F'S **DISABILITY PROCESS**

In the presence of terminal illness and incapacitation





WHAT TO DO?

What steps can an active member's family take in order to be protected in the event of terminal illness and incapacitation?

EMPLOYMENT STATUS

AT TIME OF DEATH

Disability benefit type and annuity payment amount varies based on a member's payroll status at the time of death.

Employment Status

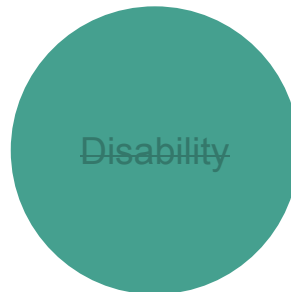
OFF-PAYROLL

When a member is removed from active payroll prior to death, the surviving family is eligible to apply for disability benefits.



ON-PAYROLL

If a member is not removed from active payroll prior to death, the surviving family is ineligible to apply for disability benefits.



Annuity Selection

VALID

If a valid annuity form is completed prior to death, up to a 100% JSA can be selected



INVALID

If a valid annuity form is not completed prior to death, up to a 50% JSA can be selected



DOCUMENTS TO FILE WITH OP&F PRIOR TO DEATH

In order to file for disability, specific documents must be signed and notarized prior to the member's death.

Required documents will vary based on the member's membership status and degree of incapacitation.

Ohio Police & Fire Pension Fund
140 East Town Street / Columbus, Ohio 43215-0184 / Tel: (614) 228-2975 / www.op-f.org

Deferred Retirement Option Plan (DROP) Affidavit for Active Employment

Ohio Police & Fire Pension Fund

ANNUITY PAYMENT PLAN SELECTION FOR OP&F BENEFITS

Please complete this form and file it with the Ohio Police & Fire Pension Fund (OP&F) if you are an OP&F member who is applying for benefits or you are a member plan selection. It is important to remember that while this form provides general information, it does not constitute a contract. For more information, please refer to the Member's Guide to Annuity Payment Plan Selection.

Choosing an annuity plan upon application
If you are married on the effective date of plan selection that provides for less than there is a court order that requires you to process your benefits on the basis of a

Ohio Police & Fire Pension Fund

LIMITED DURABLE POWER OF ATTORNEY

This Limited Durable Power of Attorney form authorizes another person (called an "attorney-in-fact") to make decisions for you. If you are not a member of the Ohio Police & Fire Pension Fund, this form cannot be used for any other purpose, such as to receive benefits, etc.

Ohio Police & Fire Pension Fund

AFFIDAVIT FOR INCAPACITATION
As referenced by Ohio Administrative Code Sections 7

This form must be completed and properly notarized in order for a person to be incapacitated OP&F member. This form does not give the person who is filing on behalf of the member the authority to complete the Annuity Payment Plan Selection form.

Before me, a Notary Public in and for said state, personally appeared _____ (the member), who being by me duly sworn, deposes and says that:

- I am acting on behalf of _____ for purposes of filing a disability benefit application with the Ohio Police & Fire Pension Fund.
- The member referenced in #1 is mentally or physically impaired as a result of disability with respect to which the attending physician, Dr. _____, finds that there is no present indication of recovery.

3. My relationship to the member referenced in #1 is that of _____.

4. In addition, I hereby certify that the information in the disability benefit application is true and correct to the best of my knowledge and belief.

5. This affidavit and accompanying disability benefit application are being filed with the Ohio Police and Fire Pension Fund, 140 East Town Street, Columbus, Ohio 43215.

Further affiant sayeth naught.

Signature of Affiant: _____

Notary public requirement

The notary public in good standing must sign in the space provided in this form.

The foregoing was acknowledged before me by the person named as the member on this _____ day of _____, 2015.

Affix Seal here

Deliver to: Member Services/Disabilities
225 4/1/2015. Previous versions obsolete.

Ohio Police & Fire Pension Fund

DISABILITY BENEFIT APPLICATION

Please read OP&F's Member's Guide to Disability Benefits prior to completing this application. If you have questions about eligibility, deadlines, or any part of the disability process, you are encouraged to speak with an OP&F disability case manager by phoning 888-864-8363.

- Once processed, OP&F must notify your employer that a person with your position or rank has filed a Disability Benefit Application. However, you will not be identified by name.
- Any misrepresentation of the facts relating to your Application might result in civil and criminal penalties, in addition to the termination of your disability benefits.

If this Application is filed by a person other than the member listed in Section A below, please attach a power of attorney or letter of guardianship (this person cannot self-designate as a beneficiary without a power of attorney). Unless otherwise incapacitated, this application should be completed by the member named below.

Complete Sections A through I and answer all questions. If a section does not apply to your situation, indicate "N/A" for "Not Applicable." Section J must be completed in the presence of a Notary Public after swearing or affirming an oath. Submit all pages of completed application to address above. Please type or print using blue or black ink.

Section A: Member information

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

Street Address / Post office box _____

City, State, ZIP code _____

Primary phone _____ ☐ New Alternate phone _____ ☐ New Email address _____ ☐ New

Employer (current or most recent) _____ Division ☐ Police ☐ Fire Job title or rank _____

Current payroll status (check all that apply):
☐ Unrestricted/full duty ☐ Paid administrative leave, since: _____
☐ Restricted/light duty since: _____ ☐ Receiving workers' compensation benefits
☐ Using vacation/sick time to remain on payroll ☐ Voluntary separation effective: _____
☐ Paid injury leave, since: _____ ☐ Involuntary separation effective: _____
☐ Other: _____

Section B: Other Ohio retirement systems

List your status with the Ohio retirement systems below. Check all that apply.

☐ Member has no association with an Ohio retirement system, other than OP&F

| | Currently receiving service or disability benefits | Currently contributing | Contributed prior to OP&F membership | Prior contributions were for full-time employment | Dates of full-time employment prior to OP&F membership, or, if currently receiving retirement benefits, list retirement date |
|--|--|--------------------------|--------------------------------------|---|--|
| Ohio Highway Patrol Retirement System | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Ohio Public Employees Retirement System | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| State Teachers Retirement System of Ohio | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Ohio School Employees Retirement System | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| Cincinnati Retirement System | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

Deliver to: Member Services
0041 9/24/2013. Previous versions obsolete.

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Disability Benefit Application
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DOCUMENTS TO FILE WITH OP&F

PRIOR TO DEATH

APPLICATION

✓ Section A: Member information



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

DISABILITY BENEFIT APPLICATION

Please read OP&F's *Member's Guide to Disability Benefits* prior to completing this application. If you have questions about eligibility, deadlines, or any part of the disability process, you are encouraged to speak with an OP&F disability case manager by phoning 888-864-8363.

- Once processed, OP&F must notify your employer that a person with your position or rank has filed a Disability Benefit Application. However, you will not be identified by name.
- Any misrepresentation of the facts relating to your Application might result in civil and criminal penalties, in addition to the termination of your disability benefits.

If this Application is filed by a person other than the member listed in Section A below, please attach a power of attorney or letter of guardianship (this person cannot self-designate as a beneficiary without a power of attorney). Unless otherwise incapacitated, this application should be completed by the member named below.

Complete Sections A through I and answer all questions. If a section does not apply to your situation, indicate "N/A" for "Not Applicable." Section J must be completed in the presence of a Notary Public after swearing or affirming an oath. Submit all pages of completed application to address above. Please type or print using blue or black ink.

| Section A: Member information | | | |
|--|--|--|--|
| Name: First, MI, Last, suffix (Jr., III, etc.) | | <input type="checkbox"/> Male <input type="checkbox"/> Female | Last 4 digits of Social Security Number [][][][] (OP&F use only) |
| Street Address / Post office box | | Date of Birth [][][][][][][][][] | |
| City, State, ZIP code | | | |
| Primary phone <input type="checkbox"/> New | Alternate phone <input type="checkbox"/> New | Email address <input type="checkbox"/> New | |
| Employer (current or most recent) | | Division <input type="checkbox"/> Police <input type="checkbox"/> Fire | Job title or rank |
| Current payroll status (check all that apply) | | | |
| <input type="checkbox"/> Unrestricted/full duty | | <input type="checkbox"/> Paid administrative leave, since: _____ | |
| <input type="checkbox"/> Restricted/light duty since: _____ | | <input type="checkbox"/> Receiving workers' compensation benefits | |
| <input type="checkbox"/> Using vacation/sick time to remain on payroll | | <input type="checkbox"/> Voluntary separation effective: _____ | |
| <input type="checkbox"/> Paid injury leave, since: _____ | | <input type="checkbox"/> Involuntary separation effective: _____ | |
| | | <input type="checkbox"/> Other: _____ | |

| Section B: Other Ohio retirement systems | | | | |
|--|--|--------------------------|--------------------------------------|---|
| List your status with the Ohio retirement systems below. Check all that apply. | | | | |
| <input type="checkbox"/> Member has no association with an Ohio retirement system, other than OP&F | | | | |
| | Currently receiving service or disability benefits | Currently contributing | Contributed prior to OP&F membership | Prior contributions were for full-time employment |
| Ohio Highway Patrol Retirement System | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ohio Public Employees Retirement System | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| State Teachers Retirement System of Ohio | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ohio School Employees Retirement System | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cincinnati Retirement System | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

APPLICATION

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DOCUMENTS TO FILE WITH OP&F

PRIOR TO DEATH

APPLICATION

- ✓ Section A: Member information
- ✓ Section E: Disabling medical conditions
- ✓ Sections J&K: Member authorization and affidavit & Notary public requirement

Section J: Member authorization and affidavit

This section must be completed in the presence of a Notary Public after swearing or affirming an oath.

TO THE NOTARY PUBLIC

Prior to completing the section below, please adequately identify the affiant, administer an oath or affirmation to the affiant (ex. "Do you affirm that the facts set forth in the affidavit are true?"), have the affiant sign the affidavit in your presence and complete and execute the certification below.

MEMBER AUTHORIZATION AND AFFIDAVIT

- I authorize any licensed physician, medical provider, medical facility or provider of health care or similar entity to release any and all of the following information to OP&F or its third party administrators: Medical information with respect to any physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, and mental health. I understand that if there are any expenses for releasing this information, it is my responsibility to pay those expenses.
- I hereby provide written authorization as required by the Fair Credit Reporting Act (FCRA), 15 U.S.C. §1681-1681y, to furnish consumer reports, including Ohio Bureau of Workers' Compensation claim information.
- I understand the information obtained will be included as part of the proof of claim and will be used to determine eligibility for benefits, return to employment opportunities, and assessment of ongoing treatment. Any information obtained will not be released to any person or organization except OP&F and its third party administrators.
- I agree that a photographic copy of this Authorization shall be as valid as the original. I understand that I may request a copy of this Authorization. This Authorization shall become effective on the date appearing next to my signature below.
- Being duly sworn, I, the member described in Section A, state that the information I provided in this Application is complete and true to the best of my knowledge and belief. I understand that, by applying for disability benefits, I am consenting to undergo medical examinations by an OP&F-appointed, independent medical examiner(s) and/or vocational evaluator(s) and authorize my physician(s) to provide OP&F with my medical information.
- I acknowledge that, if my application is approved, I must accept the award and terminate employment not later than ninety days after receiving written notice of the disability award. I acknowledge that if I do not meet this deadline, my application will be void, my disability benefit will not be paid and will be forfeited, and, if I am eligible, I may file a new disability application.
- I acknowledge that I have received and reviewed OP&F's *Member's Guide to Disability Benefits* concerning disability benefits. If I am approved by the OP&F Board of Trustees for disability benefits, I acknowledge that this approval may be contingent upon my receiving continued treatment for my disabling condition(s). Additionally, I acknowledge that my disability benefits will be terminated should I return to work as a police officer or firefighter, as defined in Rule 742-3-20 of the Ohio Administrative Code.

Member's signature:

Date of signature:

Section K: 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 Benefit Application* was sworn or affirmed before me and signed in my presence by the member named in the foregoing Section A, this _____ day of _____, 20_____.

Affix Seal here

Notary's signature:

Print name:

My commission expires:

DOCUMENTS TO FILE WITH OP&F

PRIOR TO DEATH

AFFIDAVIT

- Mentally or physically impaired
- Does *not* authorize JSA 100% selection
- No indication of recovery per a physician



Ohio Police & Fire Pension Fund
140 East Town Street
Columbus, OH 43215
Phone: 1-888-864-8383
Fax: (614) 628-1777
www.op-f.org

AFFIDAVIT FOR INCAPACITATION

As referenced by Ohio Administrative Code Sections 742-3-12 and 742-3-13

This form must be completed and properly notarized in order for a person to apply for disability benefits on behalf of an incapacitated OP&F member. This form does not give the person who is filing the Disability Benefit Application on the member's behalf the authority to complete the Annuity Payment Plan Selection Form.

Before me, a Notary Public in and for said state, personally appeared _____ (name of person acting for member), who being by me duly sworn, deposes and says that:

1. I am acting on behalf of _____ (OP&F member) SSN: _____ for purposes of filing a disability benefit application with the Ohio Police & Fire Pension Fund.
2. The member referenced in #1 is mentally or physically impaired as a result of a mental or physical illness or condition of disability with respect to which the attending physician, Dr. _____, practicing at: _____
Street address: _____
City, State, ZIP code: _____
finds that there is no present indication of recovery.
3. My relationship to the member referenced in #1 is that of _____.
4. In addition, I hereby certify that the information in the disability benefit application is true and accurate to the best of my knowledge and belief.
5. This affidavit and accompanying disability benefit application are being mailed on _____ to the Ohio Police and Fire Pension Fund, 140 East Town Street, Columbus, Ohio 43215.

Further affiant sayeth naught.

Signature of Affiant: _____ Date of signature: _____

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 was acknowledged before me by the person named above.

this _____ day of _____, 20____.

Affix Seal here

Notary's signature: _____

Print name: _____

My commission expires: _____

DOCUMENTS TO FILE WITH OP&F

PRIOR TO DEATH

AFFIDAVIT

- Member in DROP
- Termination of employment before accepting grant:
 - DROP vests
 - Disability null/void



140 East Town Street / Columbus, Ohio 43215-5164 / Tel. (614) 228-2975 / www.op-f.org

Deferred Retirement Option Plan (DROP) Affidavit for Active Employment

State of Ohio:

ss:

County of _____:

Before me, a Notary Public in and for said state, personally appeared _____,
SSN _____ who being by me duly sworn, deposes and says that:

1. I am currently on active payroll status.
2. I understand that termination of my active service at any time during the disability application process will render my disability application null and void, as well as immediately vest my DROP benefit. In this event, I understand that I must apply for a service pension.
3. Furthermore, if a disability grant is offered to me, I must accept the grant on a form provided by OP&F prior to termination of active employment.
4. Should my active service be terminated, I agree to immediately notify OP&F in writing of the date of termination.
5. In addition, I certify that the information in this affidavit is true and accurate to the best of my knowledge and belief.
6. I understand that OP&F will rely upon this Affidavit in processing my application for disability benefits, and I will indemnify OP&F for any losses arising out of a breach of the certifications stated herein.

Further affiant sayeth naught.

Signature of Affiant

Sworn to before me and signed in my presence this _____ day of _____, 20_____.

Signature of Notary

SEAL

My Commission Expires: _____



DOCUMENTS TO FILE WITH OP&F

PRIOR TO DEATH

ANNUITY

- Member or person with valid POA or court order authorizing designation may complete form.



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

ANNUITY PAYMENT PLAN SELECTION FOR OP&F BENEFITS

Please complete this form and file it with the Ohio Police & Fire Pension Fund (OP&F) if you are an OP&F member who is applying for benefits or you are a member who is receiving interim benefits and wishes to change your annuity payment plan selection. It is important to remember that the instances when you can change an annuity payment plan are limited.

While this form provides general information regarding OP&F's annuity plans, it cannot, and does not, address all exceptions and limitations that may be applicable. For more information on annuity payment plans, please see OP&F's *Member's Guide to Annuity Payment Plans* or contact OP&F Customer Service for assistance.

Choosing an annuity plan upon application for benefits

If you are married on the effective date of your benefits, Ohio law requires the written consent of your spouse for any annuity plan selection that provides for less than a 50 percent Joint and Survivor Annuity (JSA) payable to your spouse, unless there is a court order that requires you to designate a former spouse as a beneficiary. Otherwise, OP&F is required to process your benefits on the basis of a 50 percent JSA payable to your spouse.

Also, if you are a member who participated in the Deferred Retirement Option Plan (DROP) and selected a Joint and Survivor Annuity plan upon entry into DROP, you cannot re-select the annuity payment plan at retirement, unless you are under a court order to designate a former spouse as a beneficiary at the time of retirement.

Changing an annuity plan once receiving benefits

If you are receiving interim benefit payments from OP&F, you can use this form to change your annuity payment plan, provided you do so before negotiating the first adjusting or regular benefit payment that represents the final benefit amount payable to you, subject to certain restrictions. Once your benefits are finalized, you can cancel any optional plan that you may have selected (i.e., JSA) and have your benefits processed on the basis of a Single Life Annuity (SLA), subject to certain limitations, provided that the cancellation request is received no later than one year after your receipt of your first final benefit payment. After this first year, your annuity payment plan can only be changed in specific situations, which are outlined in OP&F's *Member's Guide to Annuity Payment Plans*.

| Section A: Member information | | | |
|--|--|--|---|
| Name: first, middle initial, last, suffix (Jr., III, etc.) | | <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Police officer <input type="checkbox"/> Firefighter |
| Street / Post office box | | Home telephone | |
| City, state, ZIP code | | Alternate telephone | |
| Social Security number | | Date of birth | |
| Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Married, but previously divorced | | | |
| If you have been divorced, you must file copies of all decree(s) of divorce or dissolution or marriage with OP&F for proper designation of your beneficiary. | | | |
| If married, spouse's name: first, middle initial, last | | | |
| Marriage date(s): | | | |
| Divorce date(s): | | | |

DOCUMENTS TO FILE WITH OP&F

PRIOR TO DEATH

ANNUITY

- Member or person with valid POA or court order
- JSA 100% provides maximum benefit to beneficiaries

☐

Initial here
to choose
this plan.

Single Life Annuity

I hereby authorize OP&F to pay my benefits on the basis of a single life annuity payment plan, which provides for the highest monthly amount I am entitled to receive throughout my life and, upon my death, no annuity will continue to my spouse, if applicable, or to another beneficiary.

- **Spousal consent required:** If you are married on your effective date of retirement, Ohio law requires the consent of your spouse in the form provided in Section F for an annuity selection that provides for less than a 50 percent JSA payable to your spouse, unless there is a court order that requires you to designate a former spouse as a beneficiary. Otherwise, OP&F is required by law to process your selection based on a 50 percent JSA payable to your spouse.

☐

Initial here
to choose
this plan.

Joint & Survivor Annuity

I hereby authorize OP&F to pay my benefits on the basis of the following joint and survivor annuity payment plan and agree to accept a reduced monthly allowance from OP&F so that my beneficiary listed below will be entitled to receive a lifetime monthly allowance equal to _____ percent of my reduced monthly allowance, payable upon my death.

- **Documentation required:** Copies of your birth certificate and your beneficiary's birth certificate. Also a copy of a marriage certificate if the beneficiary is your spouse.
- **Spousal consent required:** If you are married on your effective date of retirement, Ohio law requires the consent of your spouse in the form provided in Section F for an annuity selection that provides for less than a 50 percent JSA payable to your spouse, unless there is a court order that requires you to designate a former spouse as a beneficiary. Otherwise, OP&F is required by law to process your selection based on a 50 percent JSA payable to your spouse.

Provide the following beneficiary information: Is the beneficiary listed below your spouse? ☐ Yes ☐ No

| | | |
|--|--------------|------------------------|
| Name: First, MI, Last, Suffix (Jr., III, etc.) | Relationship | Social Security Number |
| Street / P.O. Box | | |
| City, State, ZIP Code | Home phone: | Date of Birth |

☐

Initial here
to choose
this plan.

Life Annuity Certain and Continuous

I hereby authorize OP&F to pay my benefit that I am eligible to receive based on the following life annuity certain and continuous payment plan with a guaranteed period of _____ years. I understand that my designated beneficiary listed below will only be paid if I die before the expiration of the guaranteed period, which begins on the effective date of my retirement, and that my beneficiary will receive my reduced monthly allowance throughout the balance of this guaranteed period. If my designated beneficiary and I both die before the expiration of the guaranteed period, then the present value of such payments shall be paid to the estate of the person last receiving the allowance.

- **Documentation required:** A copy of your birth certificate.
- **Spousal consent required:** If you are married on your effective date of retirement, Ohio law requires the consent of your spouse in the form provided in Section F for an annuity selection that provides for less than a 50 percent JSA payable to your spouse, unless there is a court order that requires you to designate a former spouse as a beneficiary. Otherwise, OP&F is required by law to process your selection based on a 50 percent JSA payable to your spouse.

Provide information below about your spouse/beneficiary in the case of your death.

| | | |
|--|--------------|------------------------|
| Name: First, MI, Last, Suffix (Jr., III, etc.) | Relationship | Social Security Number |
| Street / P.O. Box | | |
| City, State, ZIP Code | Home phone: | Date of Birth |

Multiple Beneficiary Annuity Plan

If you wish to select this plan, **do not complete this form.** Please contact OP&F for a separate Annuity Payment Plan Selection for Multiple Beneficiaries form.

DOCUMENTS TO FILE WITH OP&F

PRIOR TO DEATH

ANNUITY

- Member or person with valid POA or court order
- JSA 100% provides maximum benefit to beneficiaries
- If not properly completed, JSA 50% maximum

Section D: Member signature and acknowledgement

I, the member described in section A of this *Annuity Payment Plan Selection for OP&F Benefits*, who, having been duly sworn, represent that I am the person herein described, and I certify that all statements made herein are true and correct. I understand that my OP&F benefits will not be processed until OP&F receives this form and any other documentation required to process benefits. I understand that Ohio law may prevent OP&F from processing my annuity payment plan selection if I am married and did not provide the required spousal consent or if I am under a court order to designate a former spouse as a beneficiary under an annuity payment plan and did not do so.

I understand and agree that this annuity plan selection replaces any prior plan selection once received by OP&F and can only be changed in certain limited circumstances.

Member's Signature

Date of Signature

Section E: 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 *Annuity Payment Plan Selection For OP&F Benefits* was acknowledged before me by the member named in Section A, this _____ day of _____, 20____.

Affix Seal Here

Notary signature

Print name

My Commission Expires

Section F: Spousal consent for less than mandated annuity payment plan

I am the spouse of the OP&F member identified in Section A of the *Annuity Payment Plan Selection for OP&F Benefits*. I understand that under Ohio law, I am entitled to receive a monthly annuity of at least 50% of the member's lesser benefit allowance upon the member's death, unless there is a court order issued under Ohio Revised Code Sections 3105.171 or 3105.65 or the laws of another state regarding the division of marital property that requires the designation of a former spouse as a beneficiary under an annuity payment plan. If no such court order exists, I understand that the member's selection under Section C of this form that provides for less than 50% of the member's lesser benefit allowance to me will not be effective without my consent, which can only be evidenced by my notarized signature below.

If I grant this consent, I understand that I will not receive the mandated annuity payment plan (i.e., a 50% Joint and Survivor Annuity) and OP&F has no obligation to provide any survivor benefit to me other than those mandated by law. I agree that my spouse and OP&F have informed me of the consequences of the member's annuity payment plan selection and I understand the consequence of me signing this section. By signing this consent, I am waiving any rights that I would otherwise have under a 50% Joint and Survivor Annuity, except as otherwise provided by law. I also understand that my consent is irrevocable once filed with OP&F, except as otherwise provided by law. The signing of this consent is my free and voluntary act.

Spouse's Signature

Date of Signature

Section G: 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 *Annuity Payment Plan Selection For OP&F Benefits* was acknowledged before me by the member's spouse named in the foregoing Section F, this _____ day of _____, 20____.

Affix Seal Here

Notary signature

Print name

My Commission Expires

DOCUMENTS TO FILE WITH OP&F

PRIOR TO DEATH

DURABLE POA

- Effective upon execution
- Continues until member death/revocation
- POA can designate self as beneficiary with self-dealing provision
- Seek legal advice prior to signing



Ohio Police & Fire Pension Fund
140 East Town Street
Columbus, OH 43215
Phone: 858-864-8383
Fax: (614) 628-1777
www.op-f.org

LIMITED DURABLE POWER OF ATTORNEY

This Limited Durable Power of Attorney form authorizes another person (called an "attorney-in-fact") to make decisions for you concerning your Ohio Police and Fire Pension Fund (OP&F) account and related benefits. It is not a general power of attorney and does not grant another person the broad authority to act for you (i.e., this document does not give another person the authority to act on anything other than your OP&F account and related benefits. It cannot be used for any other purpose, such as banking transactions, real property, personal property, insurance, other government benefits, etc.).

By executing this form, you are giving your attorney-in-fact the ability to make decisions and act for you whether or not you are able to do so yourself. Therefore, you should select someone you trust to serve as your attorney-in-fact. Your attorney-in-fact's authority will begin immediately upon execution of this form and will continue until you die or revoke the Limited Durable Power of Attorney, or until your attorney-in-fact resigns or is unable to act for you.

OP&F is providing this Limited Durable Power of Attorney form to its membership as a courtesy. Due to the significance of this document, OP&F recommends that you seek legal advice before signing this document and any questions regarding its use should be directed to your personal legal counsel.

Section A: Member information

| | | | |
|---|--|--|------------------------------|
| Name: First, MI, Last, suffix (Jr, III, etc.) | | Social Security number | |
| Street Address / Post office box | | <input type="text"/> | |
| City, State, ZIP code | | Date of Birth | |
| <input type="text"/> | | <input type="text"/> | |
| Phone | <input type="checkbox"/> New Alternate phone | <input type="checkbox"/> New Email address | <input type="checkbox"/> New |

Section B: Designation of attorney-in-fact

I, the OP&F member named in Section A above, hereby name the following person as my attorney-in-fact for purposes of acting pursuant to the authority granted by me in Section D of this document.

| | |
|--|---------------|
| Attorney-in-fact name: First, MI, Last, suffix (Jr, III, etc.) | |
| Street Address / Post office box | |
| City, State, ZIP code | |
| Phone | Email address |

Section C: Designation of successor attorney-in-fact (optional)

If my attorney-in-fact is unable or unwilling to act for me, I name the following person as my successor attorney-in-fact for purposes of acting pursuant to the authority granted by me in Section D of this document.

| | |
|--|---------------|
| Successor attorney-in-fact name: First, MI, Last, suffix (Jr, III, etc.) | |
| Street Address / Post office box | |
| City, State, ZIP code | |
| Phone | Email address |



REVIEW DISABILITY PROCESS

Terminal member must be removed from payroll prior to death.

Forms to be completed prior to death:

- ✓ Disability Benefit Application
 - ✓ Affidavit for Incapacitation
 - ✓ DROP Affidavit
 - ✓ Annuity Payment Plan Selection
 - ✓ Limited Durable POA
- 