



1977 POLICE OFFICERS' & FIREFIGHTERS' FUND AFFIDAVIT FOR LINE OF DUTY DISABILITY EXPOSURE RISK

State Form 57143 (R2 / 10-25)

This completed, signed, and dated affidavit must be submitted to the MEMBER'S EMPLOYER.

Do not submit this form to INPRS.

**INDIANA PUBLIC RETIREMENT SYSTEM
1977 POLICE OFFICERS' & FIREFIGHTERS' PENSION & DISABILITY FUND**

One North Capitol Avenue, Suite 001
Indianapolis, IN 46204-2014

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* This agency is requesting disclosure of Social Security numbers in accordance with Internal Revenue Code 3405; disclosure is mandatory, and this form cannot be processed without it.

INSTRUCTIONS

1. **DO NOT SUBMIT THIS FORM TO INPRS. SUBMIT THIS FORM TO YOUR EMPLOYER.**
2. Type or print using black ink.
3. This completed, signed, and dated form may be faxed, mailed, or delivered to the member's employer.
4. Questions? Call customer service, Toll-free at (888) 876-2707, Monday through Friday.

MEMBER INFORMATION

Member name		Social Security number (last 4 digits)*		Pension ID (PID) number	
Employer's name				Submission Unit ID	
Member address (number and street)				Date of affidavit (mm/dd/yyyy)	
City		State	ZIP Code	Telephone number with area code	

MEMBER AFFIDAVIT

The following are set out in [IC 5-10-13-1](#).

1. **Exposure risk disease** refers to the following. (Select applicable disease as outlined in [IC 5-10-13-1](#)):

<input type="checkbox"/> anthrax	<input type="checkbox"/> human immunodeficiency virus (HIV)
<input type="checkbox"/> hepatitis	<input type="checkbox"/> meningococcal meningitis
<input type="checkbox"/> smallpox	<input type="checkbox"/> tuberculosis
<input type="checkbox"/> any variant of severe acute respiratory syndrome (SARS), including coronavirus disease (COVID-19)	
2. **Exposure risk disease** selected in Item 1 requires that the employee has been diagnosed with a health condition caused by an exposure risk disease that:
 - requires medical treatment; and
 - results in total or partial disability or death.
3. If the health condition results in disability or death and the employee wishes to have a presumption of disability or death incurred in the line of duty apply to the employee, the employee shall, by written affidavit executed before death, provide verification that the employee has not, outside the scope of the employee's current employment, been exposed to the exposure risk disease selected in Item 1.
 - A presumption of disability incurred in the line of duty may be rebutted by competent evidence. In the case of a SARS variant-related (i.e., COVID) diagnosis, the diagnosis and this affidavit must be dated after June 30, 2021.
 - A meeting or hearing held to rebut a presumption of disability or death incurred in the line of duty may be held as an executive session under [IC 5-14-1.5-6.1\(b\)\(1\)](#).

I affirm the following under the penalties of perjury; that I am the person making the following statements:

- I have carefully read or had read to me, the entire completed form and understand the same.
- The information I have provided is full, complete, and true, and no material fact has been concealed or omitted.
- In the case of a SARS variant-related (i.e., COVID) diagnosis, to the best of my knowledge and belief, I have not had exposure outside of my employment.

This affidavit is made for presentation to my employer in making a claim for benefits according to 1977 Police Officers' and Firefighters' Pension and Disability Fund statutes, [IC 5-10-13-5](#).

Member signature		Date (mm/dd/yyyy)
Did the member or another person complete this form? (Select one) <input type="checkbox"/> Member <input type="checkbox"/> Another person		Printed name of person completing the form

**INSTRUCTIONS FOR
1977 POLICE OFFICERS' & FIREFIGHTERS' FUND AFFIDAVIT FOR LINE OF DUTY DISABILITY
EXPOSURE RISK**

State Form 57143

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Entry field	Field description
MEMBER INFORMATION	
Member name	Enter the complete name of the member.
Social Security number*	Enter the last 4 digits of the member's Social Security number.
Pension ID (PID) number	Enter the member's Pension ID (PID) number.
Employer's name	Enter the member's employer's name
Submission Unit ID	Enter the employer's submission unit ID with INPRS
Date of application	Enter the date this affidavit was completed. Format = mm/dd/yyyy.
Member address, City, State, ZIP Code	Enter the member's mailing address (<i>number and street</i>).
Telephone number with area code	Enter the member's telephone number with area code.
MEMBER AFFIDAVIT	
1. Exposure risk disease	Select the applicable disease.
2. Exposure risk disease	Explanation of what constitutes an exposure risk disease.
3. If the health condition results in . . .	Attestation to no outside exposure to the exposure risk disease and rebuttal information. Confirmation that for any SARS-related exposure this affidavit must be to the best of the member's knowledge and belief, that the member has not had exposure outside of the member's employment.
I affirm the following under the penalties of perjury . . .	Read the entire section before signing.
Member signature	This affidavit must be signed and dated before submission to the member's employer.
Date	This affidavit must be signed and dated before submission to the member's employer. Format = mm/dd/yyyy.
Did the member or another person complete this form?	Select one
Printed name of person completing the form	Enter the person's name or enter N/A.