



**1977 POLICE OFFICERS' & FIREFIGHTERS' FUND APPLICATION FOR DISABILITY BENEFITS AND REQUEST FOR LOCAL BOARD HEARING**

State Form 10564 (R11 / 11-25)

**INDIANA PUBLIC RETIREMENT SYSTEM  
1977 POLICE OFFICERS' & FIREFIGHTERS' PENSION & DISABILITY FUND**  
One North Capitol Avenue, Suite 001  
Indianapolis, IN 46204-2014  
Telephone: (844) GO-INPRS, (844) 464-6777 (Toll-free)  
Fax: (866) 591-9441 (Toll-free)  
E-mail: [questions@inprs.in.gov](mailto:questions@inprs.in.gov)  
Web site: [www.inprs.in.gov](http://www.inprs.in.gov)

\* 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. Type or print using black ink. Complete all information and place the Member's name, Social Security number (last 4 digits), and Pension ID number at the top of each page as requested. Include an English translation of all foreign documents.
2. If not already submitted to the Indiana Public Retirement System (INPRS), you must submit such proof of age documentation for the member and spouse (if applicable) along with this application. Documents showing the date of birth may be an original or photocopy of a birth certificate, a baptismal or confirmation certificate, a legible copy of a valid driver's license, or a court decree. If such documentation cannot be provided, contact the Indiana Public Retirement System (INPRS).
3. An attorney in fact who signs for the member must submit a copy of the Power of Attorney (POA) or one must already be on file with INPRS.
4. All the above items must be provided with this application. This application will not be processed without them.
5. If this *1977 Police Officers' & Firefighters' Fund Application for Disability Benefits (State Form 10564)* is for an Exposure Risk as set out in [IC 5-10-13-1](#), **THE MEMBER MUST SUBMIT A COMPLETED, SIGNED, AND DATED [1977 Police Officers' & Firefighters' Fund Affidavit for Line of Duty Disability Exposure Risk \(State Form 57143\)](#) TO THE MEMBER'S EMPLOYER. DO NOT SUBMIT THE EXPOSURE RISK FORM TO INPRS.** Your employer will provide the *1977 Police Officers' & Firefighters' Fund Affidavit for Line of Duty Disability Exposure Risk (State Form 57143)* to INPRS if needed.
6. This completed, signed, and dated form may be faxed, mailed, or delivered to the lobby of INPRS at the address indicated on this form. The agency is closed on weekends and holidays, including all State-designated holidays.
7. Questions? Call customer service, Toll-free at (844) GO-INPRS, (844) 464-6777, Monday through Friday.

**MEMBER INFORMATION**

Member name		Social Security number (last 4 digits)*	Pension ID (PID) number
Marital status (check one) <input type="checkbox"/> Married <input type="checkbox"/> Single		Date of birth (mm/dd/yyyy)	Date of application (mm/dd/yyyy)
Address (number and street)			Telephone number with area code
City	State	ZIP Code	Email address (if applicable)

**SPOUSE INFORMATION**

This section must be completed if there is a spouse. Otherwise, it can be skipped.

Spouse name	Social Security number*	Date of birth (mm/dd/yyyy)
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**MEMBER AFFIDAVIT**

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 including the questions and the answers and understand the same.
- The information I have provided is full, complete, and true, and no material fact has been concealed or omitted.
- This application is made for presentation to INPRS in making a claim for benefits according to 1977 Police Officers' and Firefighters' Pension and Disability Fund statutes.
- **By submitting this application to the local unit, I am requesting a hearing pursuant to [IC 36-8-8-12.7](#).**

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

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Member name	Social Security number <i>(last 4 digits)*</i>	Pension ID (PID) number
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**TO BE COMPLETED BY LOCAL PENSION BOARD**

Disability period	Last day of full pay from the Department, if known <i>(mm/dd/yyyy)</i>	Class of disability
Municipality where employed	Municipality account number	Date of hire <i>(mm/dd/yyyy)</i>
Type of disability <i>(check one)</i> : <input type="checkbox"/> Converted member <input type="checkbox"/> 1977 Fund	Has the applicant been paid any income while on disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Source of income	Amount of income	

**EMPLOYER CERTIFICATION**

I hereby certify that the individual named on this form is a member of the municipality and department listed on this form and is covered by the 1977 Pension Fund. I further certify that, there is no suitable and available work within the department, considering reasonable accommodation to the extent required by the Americans with Disabilities Act for which the member is or may be capable of becoming qualified. Should this individual return to work, I will notify INPRS in writing.

Member name	Work status <i>(Choose one)</i> <input type="checkbox"/> Able <input type="checkbox"/> Unable	
Chief of department	Department name	Telephone number with area code
Chief of department signature	Date <i>(mm/dd/yyyy)</i>	

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**IMPORTANT**

1. Type or print using black ink. Complete all information and place the Member's name, Social Security number (last 4 digits), and Pension ID number at the top of each page as requested. Include an English translation of all foreign documents.
2. If not already submitted to the Indiana Public Retirement System (INPRS), you must submit such proof of age documentation for the member and spouse (if applicable) along with this application. Documents showing the date of birth may be an original or photocopy of a birth certificate, a baptismal or confirmation certificate, a legible copy of a valid driver's license, or a court decree. If such documentation cannot be provided, contact the Indiana Public Retirement System (INPRS).
3. An attorney in fact who signs for the member must submit a copy of the Power of Attorney (POA) or one must already be on file with INPRS.
4. All the above items must be provided with this application. This application will not be processed without them.
5. If this *1977 Police Officers' & Firefighters' Fund Application for Disability Benefits (State Form 10564)* is for an Exposure Risk as set out in [IC 5-10-13-1](#), **THE MEMBER MUST SUBMIT A COMPLETED, SIGNED, AND DATED [1977 Police Officers' & Firefighters' Fund Affidavit for Line of Duty Disability Exposure Risk \(State Form 57143\)](#) TO THE MEMBER'S EMPLOYER. DO NOT SUBMIT THE EXPOSURE RISK FORM TO INPRS.** Your employer will provide the *1977 Police Officers' & Firefighters' Fund Affidavit for Line of Duty Disability Exposure Risk (State Form 57143)* to INPRS if needed.
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Entry field	Field description
<b>MEMBER INFORMATION</b>	
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.
Marital status	Select <b>Married</b> or <b>Single</b> , check one.
Date of birth	Enter the member's date of birth. Format = mm/dd/yyyy.
Date of application	Enter the date this application was completed. Format = mm/dd/yyyy.
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.
Email address	Enter the member's email address, if applicable.
<b>SPOUSE INFORMATION</b>	
This section must be completed if there is a spouse. Otherwise, it can be skipped.	
Spouse name	Enter the complete name of the spouse.
Social Security number*	Enter the spouse's complete Social Security number.*
Date of birth	Enter the spouse's date of birth. Format = mm/dd/yyyy.
<b>MEMBER AFFIDAVIT</b>	
<ul style="list-style-type: none"> <li>• I affirm the following under the penalties of perjury; that I am the person making the following statements:</li> <li>• I have carefully read or had read to me the entire completed form including the questions and the answers and understand the same.</li> <li>• The information I have provided is full, complete, and true, and no material fact has been concealed or omitted.</li> <li>• This application is made for presentation to INPRS in making a claim for benefits according to 1977 Police Officers' and Firefighters' Pension and Disability Fund statutes.</li> <li>• By submitting this application to the local unit, I am requesting a hearing pursuant to <a href="#">IC 36-8-8-12.7</a>.</li> </ul>	
Member signature	The member or the attorney-in-fact must sign this section of the form.
Date	The member or attorney-in-fact must include the date the form was signed. Format = mm/dd/yyyy.
Did the member or another person complete this form?	Select <b>Member</b> or <b>Another person</b> , check one.
Printed name of person completing the form	Print the name of the person completing the form.
<b>TO BE COMPLETED BY LOCAL PENSION BOARD</b>	
Disability period	Enter the disability period as approved by the pension board.
Last day of full pay from the Department	Enter the last day in pay. Format = mm/dd/yyyy.
Class of disability	Enter the class of disability as approved by the pension board.
Municipality where employed	Enter the name of the municipality where the member is/was employed.
Municipality account number	Enter the municipality account number.
Date of hire	Enter the member's date of hire. Format = mm/dd/yyyy
Type of disability	Check one of the checkboxes, as applicable.
Have the applicant received any other income while on disability?	Select <b>Yes</b> or <b>No</b> as applicable.
Source of income	If the member will receive income from another source, indicate the source.
Amount of income	If the member will receive income from another source, indicate the amount.

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Entry field	Field description
<b>EMPLOYER CERTIFICATION</b>	
I hereby certify that the individual named on this form is a member of the municipality and department listed on this form and is covered by the 1977 Pension Fund. I further certify that, there is no suitable and available work within the department, considering reasonable accommodation to the extent required by the Americans with Disabilities Act for which the member is or may be capable of becoming qualified. Should this individual return to work, I will notify INPRS in writing.	
Member name	Enter the complete name of the member.
Work status	<b>Able</b> or <b>Unable</b> , choose one.
Chief of Department	Enter the name of the chief of the department.
Department name	Enter the name of the department
Telephone number with area code	Enter the employer's telephone number with area code.
Chief of department signature	The Chief must sign and date this application.
Date	The Chief must sign and date this application. Format = mm/dd/yyyy.

<b>HELPFUL INFORMATION</b>			
	INPRS/1977 FUND	INTERNAL REVENUE SERVICE	INDIANA DEPARTMENT OF REVENUE
<b>Telephone numbers</b>	(844) GO-INPRS Toll-free	(800) 829-1040 Toll-free	(317) 233-2240 Indianapolis local
	(844) 464-6777 Toll-free	(800) 829-4477 TeleTax	(317) 232-8729 Tax questions
	(866) 591-9441 Fax Toll-free	(800) 829-4059 TDD (hearing impaired)	(317) 232-4952 TDD (hearing impaired)
			(317) 233-2329 TaxFax
<b>Web site</b>	<a href="http://www.inprs.in.gov">www.inprs.in.gov</a>	<a href="http://www.irs.gov">www.irs.gov</a>	<a href="http://www.in.gov/dor">www.in.gov/dor</a>