Reset Form

APPLICATION FOR DISABILITY BENEFITS AND REQUEST FOR LOCAL BOARD HEARING

State Form 10564 (R9 / 9-22)

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 (Toll-free)
Fax: (866) 591-9441 (Toll-free)
E-mail: questions@inprs.in.gov
Web site: 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 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. All the above items must be provided with this application. This application will not be processed without them.
4. **If this *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 *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 *Affidavit for Line of Duty Disability Exposure Risk (State Form 57143)* to INPRS if needed.**
5. 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.
6. Questions? Call customer service, toll-free, at (844) GO-INPRS, Monday through Friday, 8 a.m. to 8 p.m. ET.

MEMBER INFORMATION

Member's name	Social Security number *(last 4 digits)**	Pension ID (PID) number

Marital status *(check one)* ☐ Married ☐ 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's name	Social Security number *(last 4 digits)**	Date of birth *(mm/dd/yyyy)*

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's signature (or attorney in fact)	Date *(mm/dd/yyyy)*

Did the member or another person complete this form? *(Check one)* ☐ Member ☐ Another person	Printed name of person completing the form

TO BE COMPLETED BY LOCAL PENSION BOARD

Disability period	Last day of full pay from the Department, if known *(mm/dd/yyyy)*	Class of disability

Municipality where employed	Municipality account number	Date of hire *(mm/dd/yyyy)*

Type of disability *(check one):* ☐ Converted member ☐ 1977 Fund ☐ Disabled after separation from service	Has the applicant been paid any income while on disability? ☐ Yes ☐ No

Source of income	Amount of income

Member's name	Social Security number *(last 4 digits)**	Pension ID (PID) number

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's name			Work status *(Choose one)* ☐ Able ☐ Unable
Chief of department	Department name		Telephone number with area code
Chief's signature			Date *(mm/dd/yyyy)*

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APPLICATION FOR DISABILITY BENEFITS

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Entry field	Field description
MEMBER INFORMATION	
Member's 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 **Married** or **Single**, 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 *(number and street)*.
Telephone number with area code	Enter the member's telephone number with area code.
E-mail address	Enter the member's e-mail address, if applicable.
SPOUSE INFORMATION	
This section must be completed if there is a spouse. Otherwise, it can be skipped.	
Spouse's name	Enter the complete name of the spouse.
Social Security number*	Enter the last 4 digits of the spouse's Social Security number.*
Date of birth	Enter the spouse's date of birth. Format = mm/dd/yyyy.
MEMBER AFFIDAVIT	
Member's 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 **Member** or **Another person**, check one.
Printed name of person completing the form	Print the name of the person completing the form.
TO BE COMPLETED BY LOCAL PENSION BOARD	
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 **Yes** or **No** 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.
EMPLOYER CERTIFICATION	
Member's name	Enter the complete name of the member.
Work status	**Able** or **Unable**, 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's signature	The Chief must sign and date this application.
Date	The Chief must sign and date this application. Format = mm/dd/yyyy.

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