MCERS FORM: DIS-2
05/01/99

MONROE COUNTY EMPLOYEES RETIREMENT SYSTEM

APPLICATION FOR DISABILITY RETIREMENT
(To be filled out in ink)

MEMBERSHIP NUMBER

Submitted by: __ Member
__ Department Head

1. Claimant's Name	8. Is your disability total? ___ Yes ___ No.
2. Residence Address	9. Is your disability permanent? ___ Yes ___ No.
3. Date of Birth _____Month_____Day________Year	10. Is your disability duty related? ___ Yes ___ No.
4. Department employed in	11. When did you first notice your disability (Give date)
5. Division	12. When did you first consult a physician about your disability?
6. Title on payroll	13. Have you applied for workmen's compensation benefits?
7. Date you last attended to your duties	14. If your disability is the result of an on duty accident, give names and addresses of witnesses within the County.

15. Give full explanation of the nature and causes of your disability:

16. Name and addresses of physicians you have consulted in connection with your disability"

NAME	ADDRESS	DATES OF ATTENDANCE

The undersigned member hereby makes claim to the Monroe County Employees Retirement System for disability benefits and authorizes the above named physicians who have attended him to report directly to the Medical Advisor of the Retirement System regarding his physical condition. The undersigned member agrees that the furnishing of this form or other forms supplemental thereto by the Retirement System is not to be considered nor constitute an admission of liability by the Retirement System.

Dated at ________________________this ____________Day of ______________________________________20______________

Signature of Witness **Signature of Member**

Address of Witness

DO NOT WRITE IN THIS SPACE

Date of Hire Years of Service