RETIREMENT PLAN FOR CHICAGO TRANSIT AUTHORITY EMPLOYEES

DISABILITY ALLOWANCE BENEFITS APPLICATION

TO THE BOARD OF TRUSTEES:
I hereby make application for Disability benefits in accordance with rules and regulations provided by the Retirement Plan for CTA Employees.

PARTICIPANT'S INFORMATION

First Name | Middle Name | Last Name

Street Address | Apt. Number | City | State | Zip Code

Home Phone Number | Mobile Phone Number | Email

Badge Number | Social Security Number | Date of Birth

Occupation | Department

Area Number | Work Location | Division

CONTINUOUSLY employed since | Last Date of Work | Benefits Start Date

☐ Yes ☐ No Married

Spouse's First Name | Spouse's Middle Name | Spouse's Last Name | Spouse's Date of Birth

MAIL CHECK'S TO

Street Address | Apt. Number | City | State | Zip Code

DISABILITY DETAILS

What is the injury or illness that is preventing you from performing your duties and following your regular employment with the Chicago Transit Authority?

I have provided the Retirement Plan for CTA Employees with copies of all medical records related to my claim. ☐ Yes ☐ No.

No claim will be presented to THE BOARD OF TRUSTEES for consideration until medical records have been provided for review by the third-party physician(s) selected by THE BOARD OF TRUSTEES or until the third party physician has examined you and provided the result of the examination to the office of the Retirement Plan For CTA Employees

My disability the result of a ☐ non-occupational illness or injury ☐ occupational illness or injury? (Check One)

Have you ever been discharged from the CTA? ☐ Yes ☐ No. If yes, provide the date of discharge. _____ The date of reinstatement. _____

Have you ever received a refund of your contributions? ☐ Yes ☐ No. If yes, provide the date of repayment of contributions _____

SIGNATURE

I hereby certify that the above statements are correct. I further certify that to the best of my knowledge, my disability is not the result of any of the disqualifying causes listed in Paragraph 12.3 of the Plan. I also understand that I will be required to submit to re-examination by a doctor or panel of doctors from time to time to certify the extent of my disability. I further understand that, if I refuse to accept employment offered by the Authority that I can perform, which pays not less than 80% of the earnings which I would have accrued if I had been currently employed in the classification held prior to my disability, that my benefits will be discontinued.

Participant's Signature | Date

NOTARIZATION (Notarization REQUIRED)

State of _____

County of _____

Signed (or subscribed or attested) to before me on (date) _____ By _____

(seal)

_____
Signature of Notary Public

APPROVAL BY THE BOARD OF TRUSTEES

have reviewed the employee's record, pertinent documents, application, and applicable forms. I certify that the employee meets all eligibility requirements of the Retirement Plan for CTA Employees, and that this application is ready to be presented to THE BOARD OF TRUSTEES for consideration.

_____
Signature of Pension Representative Date