RETIREMENT PLAN FOR CHICAGO TRANSIT AUTHORITY EMPLOYEES DISABILITY ALLOWANCE BENEFITS APPLICATION

DISTRIBUTION:
Original - Pension File
Copy - Employee
Copy - Personnel File
Copy - Payroll

Date ____________________ DISABILITY ALLOWANCE NO. ____________________

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

Name: ____________________

Address ____________________ Social Security Number: ____________________

City __________ State ______ Zip Code ________ Date of Birth ____________________

Department __________ Occupation __________ Badge/Payroll No __________ Div. ______

Area Number __________ Work Location __________ Home Phone Number __________

Email Address ____________________ Mobile Phone Number __________

I have been employed continuously by the Authority or any of its predecessor Public Utilities since ____________________

My last day of work was ____________________ I am requesting that my benefits begin on ____________________

Married ☐ Yes ☐ No Name of Spouse ____________________ Spouse date of Birth __________

Checks to be mailed to ____________________

Address __________ City __________ State ______ Zip Code ________

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

____

B. I have provided the Retirement Plan for CTA Employees 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 oftice of the Retirement Plan For CTA Employees)

C. Is your disability the result of a ☐ non-occupational illness or injury ☐ occupational illness or injury? (Check One)

D. Have you ever been discharged from the CTA? ☐ Yes ☐ No If yes, please state date of discharge __________

Date of reinstatement __________

E. Have you ever received a refund of your contributions? ☐ Yes ☐ No If yes, please indicate date of repayment of contributions __________

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.

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F. NOTARIZATION (Notarization needed only if application is submitted by mail.)

State of Illinois

County of ____________________

Signed (or subscribed or attested) before me on ____________________

(date) by: ____________________

____
Signature of Notary Public

(name of person).

(seal)

I 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, in the event that if I refuse to accept employment offered by the Authority that I am capable of performing, 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.

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Signature of Applicant

I 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.

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Signature of Pension Representative

G. This application was approved by THE BOARD OF TRUSTEES on ____________________