FORM 7

ALABAMA PEACE OFFICERS' ANNUITY & BENEFIT FUND
APPLICATION FOR DISABILITY BENEFITS

TO THE BOARD OF COMMISSIONERS Date of Signature_____

In accordance with the provisions of Section II, Disability Payments, of Act No. 999, as amended, I hereby make application for disability benefits. I understand that I must be totally or permanently disabled as a result of a heart attack or of an injury received in the line-of-duty as a peace officer and not as a result of misconduct. I am aware that this benefit may not be paid to me for longer than twenty-four (24) calendar months. As an applicant for these benefits, I am also aware that the Board shall have the right to require an examination by one or more physicians on behalf of the Board and at its expense as required by Law. This expense is limited to the examination.

1. Name in full_____ 2. Present Age_____

3. Social Security Number_____ Membership No._____

4. Employer immediately prior to your disability_____

5. Date of your last active employment as a peace officer_____

6. Your job title_____

PLEASE CHECK THAT WHICH IS APPLICABLE:

7._____I have been terminated or retired from my department; therefore, no monthly contributions from me will be required.

8._____I have not been terminated or retired by my department. I understand that it is my responsibility to notify your office at such time as I terminate or retire from my position as a law enforcement officer. Upon such notification, I will discontinue the monthly $30.00 contribution.

Signature of Applicant_____

9. I will remit my $30.00 contribution by personal check by the 10th each month.

10. Name of physician_____ Telephone #_____

11. Address of physician_____

12. **OATH: I do hereby verify that the information furnished above is true and correct to the best of my knowledge and that if I am again actively employed in any capacity, I will notify the Executive Director at which time my disability payments will be stopped.**

13. Signature of Applicant_____ Telephone #_____

14. Mailing address of Applicant_____

_____

15. Beneficiary_____ Social Security #_____

16. Mailing Address of Beneficiary_____

_____

STATE OF ALABAMA, COUNTY OF_____

ON THIS_____DAY OF_____,_____, PERSONALLY APPEARED BEFORE ME THE ABOVE NAMED_____AND MADE OATH THAT THE STATEMENTS MADE ABOVE ARE TRUE.

Signature of Notary Public _____

_____

TO BE FILLED IN BY EMPLOYER AT TIME OF DISABILITY

1. **Date of last active service of peace officer**_____
2. **Has peace officer returned to work?_____If so, give date**_____
3. **Has peace officer retired?_____Date of Retirement** _____
4. **Approved by**_____**Telephone #**_____

(Title)

_____ _____

(Signature) **(Date)**

FORM 7-A

ALABAMA PEACE OFFICERS' ANNUITY & BENEFIT FUND
514 South McDonough Street
Post Office Box 2186
Montgomery, Alabama 36102-2186

APPLICATION FOR DISABILITY

1. Did you receive an injury in the line of duty or have a heart attack? Yes ☐ No ☐

2. If yes, are you totally or permanently disabled as a result of such injury or heart attack?

_____

3. Give date of injury or heart attack?_____
(If line of duty injury, please attach Departmental Injury Report.)

4. If injury, explain in detail how the injury occured?_____

_____

_____

_____

5. How soon after injury were you treated by a physician?_____

_____

6. Name of physician_____Telephone #_____

7. Address of physician_____

_____

OATH: I do hereby certify that the information furnished above is true and correct to the best of my knowledge.

_____
Signature of Applicant

Sworn to and subscribed before me this the_____day of_____,_____.

_____
Notary Public

FORM 7-B

ALABAMA PEACE OFFICERS' ANNUITY & BENEFIT FUND

MEDICAL REPORT

NOTE TO PHYSICIAN: THIS FORM IS TO BE USED ONLY IF THE PATIENT HAS SUFFERED A HEART ATTACK, HAS A SPECIFIC HEART CONDITION, OR WAS INJURED IN THE LINE-OF-DUTY.

PLEASE TYPE

1. Name of Patient_____ Age_____

2. Height_____ Weight_____ Blood Pressure_____

3. GENERAL CONDITION:

   A. Heart_____

   _____

4. Diagnosis_____

   _____

5. Conclusions_____

   _____

6. SPECIFICALLY:

   A. Has patient suffered an injury?_____

   _____

   B. Has patient suffered a heart attack?_____

   _____

   C. Does patient have a specific heart condition?_____

   _____

   D. As a result of the above, elaborate giving date when first consulted and if patient is unable to perform the duties required of him as a law enforcement officer._____

   _____

   _____

   Date of Examination_____

_____
Signature of Examining Physician

Address_____

_____

Telephone #_____

USE REVERSE SIDE FOR ANY COMMENTS