PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
POLICE AND FIREMENS' RETIREMENT SYSTEM
OF NEW JERSEY
(609) 292-7524 TDD (609) 292-7718
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ELIZABETH MAHER MUOIO
State Treasurer

ED DONNELLY
Chairman, PFRSNJ

PFRS Supplemental Application for Accidental Disability Benefits

Due to COVID-19

In accordance with P.L. 2020, c.54 (Chapter 54), an Act concerning eligibility for accidental disability benefits for certain members of the Police and Firemen's Retirement System (PFRS), this *Supplemental Application for Accidental Disability Benefits Due to COVID-19* allows eligible PFRS members the right to file for an Accidental Disability Retirement benefit should they become disabled due to exposure to the SARS-CoV-2 virus during the course of their job duties.

I hereby submit this form to attest that I was exposed to the SARS-CoV-2 virus during the public health emergency in the State of New Jersey declared by the Governor in Executive Order 103 of 2020 and as extended, and developed symptoms of COVID-19, as described below. I am aware that I must submit an *Application for Disability Retirement* via the Member Benefits Online System (MBOS) in addition to this form.

PART ONE - MEMBER INFORMATION *(To be completed by the applicant)*

Name: _____ Date of Birth: _____

Membership Number: _____ Social Security Number: _____

Address: _____

Email Address: _____ Daytime Phone: _____

Job Title: _____ Retirement Date: _____

I ATTEST THAT:

I contracted COVID-19 and tested positive for SARS-CoV-2 during the public health emergency in the State of New Jersey declared by the Governor in Executive Order 103 of 2020 and as extended, and certify the following:

- ☐ I am totally and permanently disabled from my regular or assigned job duties as a result of COVID-19.
- ☐ My regular or assigned duties required me to interact, and I did so interact, with the public or I directly supervised personnel that interacted directly with the public on any date during the public health emergency in the State declared by the Governor in Executive Order 103 of 2020 and as extended and within 14 calendar days prior to the appearance of symptoms consistent with COVID-19.
- ☐ The diagnosis has been confirmed in writing by the licensed health care provider listed below.

PART ONE - MEMBER INFORMATION *(Continued)*

Date(s) of Exposure: _____ Location of Exposure: _____

Please provide a brief synopsis of how the exposure occurred. Attach additional sheets as necessary.

_____

_____

By my signature, I attest that I have answered the questions on the *Supplemental Application for Accidental Disability Benefits Due to COVID-19* truthfully, to the best of my knowledge, information, and belief. Further, I understand that any person who knowingly and willfully makes any false statement, misrepresentation, concealment of fact, or any other act of fraud in submitting this *Supplemental Application for Accidental Disability Benefits Due to COVID-19* pursuant to the Act concerning eligibility for Accidental Disability benefits for members of the PFRS who contract COVID-19 and test positive for SARS-CoV-2 to which that person is not entitled is subject to punishment inclusive of civil and/or administrative remedies, as well as criminal prosecution which may provide for punishment of a fine or imprisonment.

Member's / Legal Guardian's* Signature: _____

Date: _____

** If the member is incapacitated, a legal guardian may complete this form. Legal documentation must be provided.*

State of _____

County of _____

Sworn and Subscribed before member this_____day of

_____, 20__

(Affix notary stamp here)

_____

Notary Public Signature

My Commission Expires: _____

PART TWO - PATIENT INFORMATION *(To be completed by the treating physician.)*

1. Name of Patient: _____ 2. Date of Birth: _____

3. Date of positive SARS-CoV-2 test: _____ Please attach copy(ies) of test results

4. Have you treated the member prior to the COVID-19 diagnosis? _____Yes _____ No

a.) If yes, for what conditions have you treated the member (include treatment dates)?

_____

_____

5. Provide related laboratory, cardiographic, x-ray, or other diagnostic data: (Please attach copies of narrative reports – no films please.)

6. a.) Is the applicant's disability likely to be stable or progressive? _____ Stable _____ Progressive

b.) If progressive, is death imminent? ____ Yes ____ No

c) Is there a possibility that the applicant might improve to a degree to perform his/her job duties?

_____ Yes _____ No

7. In your medical opinion, is the member now totally and permanently disabled from performing his/her job duties due to the contraction of COVID-19?

_____ Yes _____ No

8. Is the applicant permanently and totally disabled as a direct result of the contraction of COVID-19 which occurred during the performance of the applicant's regular assigned duties?

_____ Yes _____ No

9. Please provide a brief summary explaining your opinion. If you answered yes to #8, please explain the causal relationship. Attach any documentation supporting your opinion.

_____

_____

Name of Medical Provider confirming COVID-19 diagnosis: _____ Degree: _____

Address: _____

Email address: _____Daytime phone: _____

Specialty: _____ N.J. License No: _____

Signature of Provider: _____ Date: _____

Return Completed Forms To:

New Jersey Division of Pensions & Benefits
Disability Retirement Section
P.O. Box 295
Trenton, NJ 08625-0295

Or email to:

disabilityrets@treas.nj.gov