RD-1114-1220

State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS — RETIREMENT SECTION

P.O. Box 295, Trenton, NJ 08625-0295

COVID-19 MEDICAL QUESTIONNAIRE

In order to process your application for Accidental Disability retirement in accordance with Chapter 54, P.L. 2020, you must complete this form in its entirety and provide all requested documents not limited to, but including; an accident report, copy of positive COVID-19 test results, written documentation from a licensed health care provider indicating you are totally and permanently disabled as a result of your exposure to COVID-19 during work related duties that require interaction with the public during a Public Health Emergency declared by the Governor in Executive Order 103, of 2020, as extended within 14 days of showing symptoms consistent with COVID-19.

PART 1 — MEMBER INFORMATION

Select Retirement System ☐ SPRS ☐ PERS First Responders Membership Number _____

Name _____
Last *First* *Middle*

PART 2 — COVID-19 QUESTIONNAIRE

What was the date and location of the COVID-19 exposure that led to your alleged total and permanent disability?

Date _____/_____/_____ Location _____

Was a report of the incident filed with your employer? ☐ Yes ☐ No
If yes, list your immediate supervisor, date the report was filed, report number if any, and provide a copy of the report.

Supervisor's Name _____

Date Filed _____/_____/_____ Report Number _____

Were you tested for COVID-19 in New Jersey or any other state? ☐ Yes ☐ No
If yes, list the date(s), location(s), and results of all tests. Provide a copy of positive test results for SARS-CoV-2.

Date _____/_____/_____ Location _____ Results _____

Date _____/_____/_____ Location _____ Results _____

Please provide a copy of the work schedule or timesheet for the two weeks prior to receiving a positive test result for SARS-CoV-2.

Did you have a prescription for testing? ☐ Yes ☐ No
If yes, provide the name, address and phone number for the issuing physician.

Physician Name _____ Phone Number _____

Address _____
Street *City* *State* *Zip Code*

Were you hospitalized for treatment of COVID-19? ☐ Yes ☐ No
If yes, provide the hospital name and address, date of admission, and length of stay for any of the above noted positive tests.

Hospital Name _____

Address _____
Street *City* *State* *Zip Code*

Admission Date _____/_____/_____ Discharge Date _____/_____/_____

PART 3 — MEDICAL HISTORY

List all medical conditions for which you see a doctor _____

_____

_____

Provide the name, address and phone number for each pharmacy you use _____

_____

Who is your Primary Care Physician?

Physician Name _____ Phone Number _____

Address _____
Street *City* *State* *Zip Code*

Provide information for all physicians who have treated you within the last five years, and the medications they prescribed you, including dosage and frequency. Additional physician or prescription information can be printed and attached to this document.

Physician Name _____ Specialty _____

Address _____
Street *City* *State* *Zip Code*

Phone Number _____

List medications and pharmacy where filled _____

_____

Physician Name _____ Specialty _____

Address _____
Street *City* *State* *Zip Code*

Phone Number _____

List medications and pharmacy where filled _____

_____

PART 4 — SIGNATURE

Fraud Warning - Any person who knowingly submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an application for disability retirement benefits or a statement of claim for payment of a benefit, commits a fraudulent act and is guilty of a crime and may be subject to punishment.

I hereby certify that the information I have provided on this form is accurate to the best of my knowledge and that I have read, understand and agree with the fraud warning statement.

_____ _____/_____/_____
Member Signature *Date*

If someone other than the member has completed this form, please print your name, your relationship to the member, your phone number, and your signature.

_____ _____ _____
Print Name *Relationship to Member* *Phone Number*

_____ _____/_____/_____
Signature *Date*

You may scan this document and its attachments and email to: ***disabilityrets@treas.nj.gov***