Office of the New York State Comptroller

NYSLRS

New York State and Local Retirement System

110 State Street, Albany, New York 12244-0001

Please type or print clearly in blue or black ink

Received Date

World Trade Center Notice for Members and Retirees of the New York State and Local Retirement System RS 6047-N

(Rev. 06/23)

NYSLRS ID

Social Security Number [last 4 digits] XXX-XX-

Retirement System [check one]

Employees' Retirement System (ERS) ☐

Police and Fire Retirement System (PFRS) ☐

Please return this application to the Retirement System in an envelope marked "Personal and Confidential Mail Drop 7-1"

You must file this form with the New York State and Local Retirement System **on or before September 11, 2026**. If you are permanently incapacitated or become permanently incapacitated in the future, you will also need to file the **Application for World Trade Center Accidental Disability Presumption** (RS 6047-W) to receive the benefit. To be eligible for this presumption, the applicant must have participated in World Trade Center rescue, recovery or clean up operations for any period of time within the first 48 hours after the first airplane crashed, or a minimum of 40 hours between September 11, 2001 and September 12, 2002.

INFORMATION ABOUT YOU	
1. Name: (First, Middle Initial, Last)	2. Date of Birth:
3. Address: (Including Street, City, State and Zip Code)	4. Telephone Numbers: HOME ( ) WORK ( ) CELL ( )
5. Job Title on 9/11/2001:	6. Employer/Organization 9/11/2001:
7. Current Job Title:	8. Current Employer:

Locations:	**Dates:**	**Names and Address of Employer/Organization** Under Which Work Was Performed:**
World Trade Center Site		
Fresh Kills Landfill		
New York City Morgue		
Temporary Morgue on Pier Locations on the West Side of Manhattan		
Barges between the West Side of Manhattan and the Fresh Kills Landfill		

If you worked at any sites not listed above, list the site with the address below:

Locations:	**Dates:**	**Names and Address of Employer/Organization** Under Which Work Was Performed:**

IMPORTANT – You must complete other side

Description of Duties performed during the WTC rescue and recovery or clean up operations:

Were you required to have a physical examination for entry into public service? ☐ Yes ☐ No

If yes, for what position did you have this physical and when?

Position: _____ Date: _____ Employer: _____

If you did not have a physical exam for entry into public service, you MUST authorize the release of all relevant medical records. Please complete the Medical Records Release Authorization below.

Note: If you did not undergo a physical exam for entry into public service, NYSLRS is required to have your authorization to satisfy the requirements of the WTC Disability Law. It is recommended that you gather, maintain and/or submit relevant medical records as early as possible. Doing so may help facilitate a disability application you may file in the future.

MEDICAL RECORDS RELEASE AUTHORIZATION

I, _____, hereby authorize the release of all relevant medical psychiatric, psychological, hospital and health insurance records, including specially protected or listed records such as those relating to drug abuse, alcoholism, genetic testing, psychiatric care and/or confidential HIV/AIDS related information.

All pertinent records are authorized to be released to the New York State and Local Retirement System (NYSLRS) and will be used to determine a WTC disability and/or death claim.

I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization, I must do so in writing and it may impact my ability to qualify for disability or accidental death benefits provided under the WTC Disability Law.

By signing below I acknowledge that I have read and accept all of the above and hereby authorize any hospital, medical group, or other organization to disclose all information to the New York State and Local Retirement System.

Signature:_____ Date:_____

Please sign your name in full below:

I certify that the information on my application is true and complete to the best of my knowledge. I further certify that I am aware that any false statement I knowingly make or permit to be made on this or any record of the Retirement System constitutes a crime punishable by potential incarceration and other sanctions.

Signature:_____ Date:_____

ACKNOWLEDGEMENT TO BE COMPLETED BY A NOTARY PUBLIC

State of _____ County of _____ On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____

NOTARY PUBLIC (Please sign and affix stamp)

***Social Security Disclosure Requirement**

In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of your Social Security account number is mandatory pursuant to Sections 11, 34, 311 and 334 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

** Your Employer/Organization will be contacted to verify your involvement.

Personal Privacy Protection Law

The Retirement System is required by law to maintain records to determine eligibility for and calculate benefits. Failure to provide information may interfere with the timely payment of benefits. The System may be required to provide certain information to participating employers. The official responsible for record maintenance is the Director of Member and Employer Services, NYS and Local Retirement System, Albany, NY 12244; call toll-free at 1-866-805-0990 or 518-474-7736 in the Albany Area.

Office of the New York State Comptroller
NYSLRS
New York State and Local Retirement System
110 State Street, Albany, New York 12244-0001

Please type or print clearly in blue or black ink

Received Date

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

RS 6429
(Rev. 09/18)

Patient Name: (First, Middle Initial, Last)	Date of Birth:	Social Security Number: **XXX-XX-**
Patient Address: (Including Street, City, State and Zip Code)		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in item 8(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in item 8(a), I specifically authorize release of such information to the person(s) indicated in Item 7.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from disclosing such information, without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (1-888-392-3644) or (212-961-8650). This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider(s) listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
5. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 8(b).**

6. Name and address of health care provider(s) or entity(ies) to release this information:

7. Name and address of person(s) or category of person to whom this information will be sent:
New York State and Local Retirement System, Mail Drop 7-1, 110 State Street, Albany NY 12244

8. (a) Specific information to be release:

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, insurance records, and records sent to you by other health care providers.

☐ Other: _____
_____

Include: *(Indicate by Initialing)*
_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____ to discuss my health
Initials — Name of individual health care provider

information with my attorney or governmental agency listed here:

New York State and Local Retirement System
(Attorney/Firm Name or Government Agency Name)

9. Reason for release of information: ☐ At the request of individual ☐ Other:	10. This authorization will expire at the completion of the disability retirement application process:
11. If not the patient, name of person signing form:	12. Authority to sign on behalf of patient:

_____ _____
Signature of patient representative authorized by law — Date

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts**.