

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



**Application for
 World Trade Center
 Accidental Disability
 Presumption**

RS 6047-W

(Rev. 9/16)

INSTRUCTIONS: Please print plainly or type. The application must be signed on reverse side.
 Please call our Call Center at 1-866-805-0990 if you need help completing this application.

INFORMATION ABOUT YOU		
1. NAME	2. SEX: <input type="checkbox"/> M <input type="checkbox"/> F	3. ADDRESS:
4. REGISTRATION NUMBER: or RETIREMENT NUMBER, if retired:		5. SOCIAL SECURITY NUMBER*: XXX-XX-
		6. DATE OF BIRTH: / /
7. TELEPHONE NUMBERS: HOME () WORK () CELL ()	8. CURRENT EMPLOYER: If retired, last public employer:	
9. PAYROLL TITLE		
10. I AM PERMANENTLY DISABLED BECAUSE OF THE FOLLOWING CONDITION OR IMPAIRMENT OF HEALTH:		
11. FOR UNITED STATES TAX WITHHOLDING AND REPORTING PURPOSES (PLEASE CHECK ONE), I AM A: <input type="checkbox"/> U.S. CITIZEN <input type="checkbox"/> RESIDENT ALIEN <input type="checkbox"/> NONRESIDENT ALIEN		

12. HAVE YOU FILED A WORLD TRADE CENTER NOTICE FOR MEMBERS AND RETIREES OF THE NEW YORK STATE AND LOCAL RETIREMENT SYSTEM (FORM RS 6047-N)? Yes No

YOU MUST HAVE FILED A WORLD TRADE CENTER NOTICE BY SEPTEMBER 11, 2018.

Medical Record Information prior to September 11, 2001

13. I HAVE BEEN TREATED BY THE FOLLOWING DOCTORS: (Use additional sheets if required.)

Primary Care Physician	Doctor	Doctor
Internal Med/Family Practitioner	Medical Speciality	Medical Speciality
Street	Street	Street
City, State and Zip Code	City, State and Zip Code	City, State and Zip Code

14. LIST HOSPITALIZATIONS, IF ANY. (Use additional sheets if required)

Hospital	Dates of Admission	Hospital	Dates of Admission
Street		Street	
City, State and Zip Code		City, State and Zip Code	

Medical Record Information after September 11, 2001

15. I HAVE BEEN TREATED BY THE FOLLOWING DOCTORS: (Use additional sheets if required.)

Primary Care Physician	Doctor	Doctor
Medical Speciality	Medical Speciality	Medical Speciality
Street	Street	Street
City, State and Zip Code	City, State and Zip Code	City, State and Zip Code
Doctor	Doctor	Doctor
Medical Speciality	Medical Speciality	Medical Speciality
Street	Street	Street
City, State and Zip Code	City, State and Zip Code	City, State and Zip Code

16. LIST HOSPITALIZATIONS, IF ANY. (Use additional sheets if required)

Hospital	Dates of Admission	Hospital	Dates of Admission
Street		Street	
City, State and Zip Code		City, State and Zip Code	

17. INFORMATION ABOUT YOUR INTENDED BENEFICIARY

Beneficiary	Relationship to you (if any)
Street	Date of Birth
City, State and Zip Code	Sex

I certify that the information contained on this form is true.

Applicant Name/Title (Please Print)

Applicant Signature (Sign Name in Full)/Date

RELATIONSHIP TO MEMBER: Self Employer Other _____

(If applicant is not the member or employer, you must submit original documentation that authorizes you to file)

***NOTE:** 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 Section 11, 34, 311 and 334 of the Retirement and Social Security Law. Your number will be used in identifying your retirement records and in the administration of the Retirement System.

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 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 Services, NYS and Local Retirement Systems, Albany, NY 12244; 518-474-7736.

**AUTHORIZATION FOR RELEASE
 OF HEALTH INFORMATION
 PURSUANT TO HIPAA
 RS 6429**
 (Rev. 5/15)

Patient Name	Date of Birth	Social Security Number XXX-XX-
Patient Address		

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:

- 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.
- If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing 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.
- 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.
- 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.
- 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 released:
- 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 _____
Initials Name of individual health care provider

to discuss my health 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: <input type="checkbox"/> At the request of individual <input type="checkbox"/> 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:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of patient or representative authorized by law. _____ Date _____

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