FORM RP 011
Rev. 1/95

WATER AND POWER EMPLOYEES' RETIREMENT PLAN

ROOM 357 - 111 NORTH HOPE STREET
BOX 51111 - LOS ANGELES, CA 90051-0100

Orig. : Disability Office
1st copy: DWP Medical Office
2nd copy: Attending Physician

DISABILITY NOTICE/BENEFIT CLAIM FORM

NAME (LAST, FIRST, MIDDLE INITIAL)		HOME PHONE		DATE OF BIRTH
ADDRESS (STREET, CITY, STATE)			ZIP CODE	☐ MALE ☐ FEMALE
EMPLOYEE NO.	JOB TITLE	DIVISION	TEL EXT.	REPORTING LOCATION
IS THIS ILLNESS JOB RELATED? YES ☐ NO ☐	CAUSE: ACCIDENT ☐	ILLNESS ☐	OPERATION ☐	PREGNANCY ☐
DATE OF FIRST WORK DAY YOU WERE UNABLE TO WORK 20	I WAS HOSPITALIZED FROM		TO	

I UNDERSTAND THAT THIS CLAIM FOR BENEFITS FROM THE DISABILITY FUND IS **ONLY** FOR A DISABILITY WHICH WAS **NOT** JOB-RELATED. IF THIS DISABILITY IS LATER DETERMINED TO BE JOB-RELATED, I AGREE TO REIMBURSE THE DISABILITY FUND FOR BENEFIT PAYMENTS RECEIVED UNDER THIS CLAIM **TO WHICH I AM NOT ENTITLED.**

I ALSO UNDERSTAND THAT I SHALL NOT BE ENTITLED TO DISABILITY BENEFITS WHILE GAINFULLY EMPLOYED, EITHER PART-TIME OR FULL TIME, WITHOUT PRIOR APPROVAL BY THE BOARD OF ADMINISTRATION.

I HEREBY AUTHORIZE RELEASE OF INFORMATION AND UNDERSTAND THIS INFORMATION MAY BE USED BY THE WATER AND POWER EMPLOYEES' RETIREMENT PLAN TO DETERMINE EXTENT AND DEGREE OF PHYSICAL OR MENTAL DISABILITY. THE FINAL DETERMINATION AS TO WHETHER I AM UNABLE TO WORK, AND FOR WHAT PERIOD OF TIME, IS MADE BY THE BOARD OF ADMINISTRATION OF THE RETIREMENT PLAN BASED ON ALL AVAILABLE MEDICAL EVIDENCE. THEREFORE, I UNDERSTAND THAT THERE IS NO GUARANTEE THAT I WILL RECEIVE DISABILITY PAYMENTS FOR ALL OR ANY PART OF MY ABSENCE, EVEN WITH CERTIFICATION FROM MY TREATING PHYSICIAN.

EMPLOYEE'S SIGNATURE ______________________________

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION

(THIS AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION IS BEING REQUESTED OF YOU TO COMPLY WITH CONFIDENTIALITY OF MEDICAL INFORMATION ACT, EFFECTIVE JAN. 1, 1980, SECTION 56 ET SEQ. OF THE CALIFORNIA CIVIL CODE AND FEDERAL LAWS DEALING WITH PRIVACY AND CONFIDENTIALITY OF CERTAIN MEDICAL RECORDS.)

I HEREBY AUTHORIZE ANY PHYSICIAN, HEALTH CARE PRACTITIONER, HOSPITAL, CLINIC, PRACTITIONER OF THE HEALING ARTS, MEDICAL, DENTAL, OR MEDICALLY RELATED FACILITY TO FURNISH ALL MEDICAL INFORMATION, REPORTS, OPINIONS, FINDINGS, AND RECORDS PERTAINING TO MEDICAL HISTORY, SERVICES RENDERED OR TREATMENT GIVEN TO ME, OR MY PHYSICAL AND MENTAL CONDITION, TO THE WATER AND POWER EMPLOYEES' RETIREMENT PLAN, ITS AGENT, DESIGNEE OR REPRESENTATIVE.

I ALSO AUTHORIZE THE DEPARTMENT OF WATER AND POWER, THE WATER AND POWER EMPLOYEES' RETIREMENT PLAN, ITS AGENT, DESIGNEE OR REPRESENTATIVE TO FURNISH TO ANY PHYSICIAN, HEALTH CARE PRACTITIONER, PRACTITIONER OF THE HEALING ARTS, HOSPITAL, CLINIC, MEDICAL, DENTAL, OR MEDICALLY RELATED FACILITY ATTENDING ME, PROVIDING ME WITH MEDICAL CARE OR PROVIDING ME WITH HEALTH TREATMENT, ANY INFORMATION, RECORDS, MEDICAL, PHYSICAL OR MENTAL HEALTH DATA, WHICH MAY COME INTO ITS POSSESSION.

THIS AUTHORIZATION IS SUBJECT TO REVOCATION AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON, THE DURATION OF THE CONSENT SHALL BE NO LONGER THAN REASONABLY NECESSARY FOR FINAL DETERMINATION OF THE DISABILITY CLAIM.

I ALSO CONSENT TO THE RELEASE OF ANY AND ALL RECORDS OF ALCOHOL AND/OR DRUG ABUSE, PSYCHIATRIC OR SICKLE-CELL ANEMIA TREATMENT (P.L. 94-581) UNDER THE SAME CONDITIONS AS OUTLINED ABOVE. I UNDERSTAND THAT SUCH INFORMATION CANNOT BE RELEASED WITHOUT MY CONSENT.

THIS AUTHORIZATION IS GIVEN FOR THE PURPOSE OF REVIEW, EVALUATION AND INVESTIGATION OF MY CLAIM FOR DISABILITY BENEFITS UNDER THE WATER AND POWER EMPLOYEES' RETIREMENT PLAN, AND TO DETERMINE MY ABILITY TO PERFORM THE DUTIES OF MY POSITION.

I AGREE THAT A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

DATED ______________________________ EMPLOYEE'S SIGNATURE ______________________________

THE FEDERAL PRIVACY ACT OF 1974 (P.L. 93-579) AND OTHER GOVERNMENTAL REGULATIONS PROVIDE SECURITY IN THE TRANSFER OF PRIVILEGED COMMUNICATIONS. THE INFORMATION YOU REQUEST MAY BE OBTAINED FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY THOSE REGULATIONS, WHICH PROHIBIT ANYONE FROM MAKING ANY DISCLOSURES FROM THEM WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM THEY PERTAIN, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS.

PLEASE NOTE: ANY DISABILITY TIME OFF, WITHIN 30 DAYS OF YOUR RETURN TO DUTY FROM THIS DISABILITY, WILL REQUIRE MEDICAL CERTIFICATION FROM AN ATTENDING DOCTOR.