Oklahoma Firefighters Pension and Retirement System
4545 N. Lincoln Blvd., Suite 265
Oklahoma City, Oklahoma 73105-3407
1-800-525-7461 · (405) 522-4600 · Fax (405) 522-4643
www.okfirepen.state.ok.us

Application for Disability Retirement Pension

☐ PAID ☐ DISABILITY IN THE LINE OF DUTY

☐ VOLUNTEER ☐ DISABILITY NOT IN THE LINE OF DUTY

Before the Board of Trustees of the Oklahoma Firefighters Pension and Retirement System, _____ Fire Department, City of _____ County of _____ Oklahoma.

In re: Application for Pension of _____, pursuant to Oklahoma Statutes, Title II, Section 49-101 and 49-106, Supp. 1981.

COMES NOW _____ who hereby makes application to the Board of Trustees of the Oklahoma Firefighters
(as shown on social security card)
Pension and Retirement System for a pension and respectfully submits the following:

1. That applicant has served a period of _____ years, _____ months, and _____ days as a member of _____ Fire Department. Such service began on the _____ day of _____, _____ and ended on the _____ day of _____, _____.

2a. **(Complete if Disability is NOT in the Line of Duty)** That applicant has become permanently from causes not arising in the line of duty as a member of the _____ Fire Department, and that by reason thereof said applicant is so physically or mentally disabled as to prevent the effective performance of his duties.

2b. **(Complete if Disability is in the Line of Duty)** That applicant further shows that he/she is at this time so physically or mentally disabled as to prevent the effective performance of his/her duties as such fireman, and that he/she became so disabled as the result of an accident or illness arising out of and sustained in the course of the performance of his/her duty as such fireman and through no negligence of his/her own on the _____ day of _____, _____.

FOR OFFICE USE ONLY

RETIREMENT CODE
PAYEE CLASS
STATUS
PENSION AMOUNT

CODE _____ DEPT. NAME _____

FIREFIGHTERS SOCIAL SECURTIY NUMBER _____

SERVICE ENDED _____

EFFECTIVE DATE _____

DEDUCTIONS (if any):

FEDERAL TAX		OTHER INS.		DETAIL DUES	
STATE TAX		CREDIT UNION		OTHER A	
RETIREES DUES		MISC.		OTHER B	
MUNICIPAL INS.		MUTUAL AID		OTHER C	

SPOUSE'S NAME _____ BIRTHDATE _____ MARRIAGE DATE _____

NAME OF CHILD:	BIRTHDATE:	NAME OF CHILD:	BIRTHDATE:

ENTER DIRECT DEPOSIT INFORMATION BELOW (OR ATTACH A VOIDED CHECK TO FORM)

BANK NAME	BANK ADDRESS	ACCOUNT NUMBER

BANK PHONE NUMBER	CITY	STATE	ZIP CODE	ROUTING NUMBER

(over)

3. Applicant further shows that his/her present disability, as a result of such accident or illness is as follows:

_____

4. That said applicant has submitted himself/herself for examination in accordance with 11 O.S., Section 49-110 and the certificate of said physician duly subscribed and sworn to showing applicant's disability is attached here to.

5. Applicant further avers and verily believes that said disability will continue for an indefinite period of time.

6a. (Complete if Disability is Not In Line of Duty). Applicant further requests that he/she be retired from active service and granted a disability pension of $_____. Applicant shall be entitled to a pension during the continuance of said disability. (If applicant was a volunteer firefighter, he/she shall be entitled to a pension in the amount allowed by State law for each year of credited service, not be exceed thirty (30) years.) (If applicant was a paid fire fighter, pension shall be based on his/her last sixty months of credited service.)

6b. (Complete if Disability is In Line of Duty). Applicant further submits that he/she has in all things complied with Oklahoma Statutes, Title 11, Section 49-109 and 49-110 and therefore, respectfully requests that he/she be granted a disability pension of $_____. (If applicant was a volunteer firefighter he/she shall be entitled to the volunteer pension being paid service retirees.) (If applicant was a paid firefighter he/she shall be entitled to a monthly disability allowance equal to one-half of the average monthly salary paid to him/her during the highest salaried thirty consecutive months of the last sixty months of credited service, providing applicant has served twenty or more years. If applicant has served less than twenty years, pension will be based on his last thirty months of credited service.)

Is applicant currently participating in the Deferred Retirement Option Plan? ☐ Yes ☐ No

I, _____ authorize the Oklahoma Firefighters Pension and Retirement System ("Board") to conduct a physical examination, as required by 11 O.S. Section 49-116, in order for me to qualify to receive any disability pension benefits. Further, I consent to the release of the examination results, and any other information, including but not limited to medical information relating to the existence of my disability, if any, or any other information related to my pension benefits, to personnel authorized by the Board, participating employer, local pension board, physicians or medical personnel selected by the Board, and to Board members, for appropriate review and the determination of disability or regular pension benefits.

Dated this _____ day of _____ , _____

_____
Applicant's Signature

_____
Mailing Address

_____ _____ _____
City State ZIP Code

_____
Phone

State of Oklahoma)
) SS.
County of _____)

I hereby certify that the above and foregoing application and release was executed by _____ on this _____ day of _____ , _____ .

Subscribed and sworn to before me _____ day of _____ , _____ .

My commission expires _____

Notary Public

PLEASE ENCLOSE:

1. MINUTES OF YOUR LOCAL PENSION BOARD MEETING (if applicable) (Minutes from town counsel cannot be accepted).

2. TWO PHYSICIAN STATEMENTS STATING THAT YOU CANNOT PERFORM THE DUTIES OF A FIREFIGHTER

3. ANY AVAILABLE INJURY REPORTS

4. FEDERAL AND STATE WITHHOLDING TAX FORM (FORM 6)

5. A VOIDED CHECK FOR DIRECT DEPOSIT

Return to: **OKLAHOMA FIREFIGHTERS PENSION AND RETIREMENT SYSTEM**
4545 N. Lincoln Blvd., Suite 265
Oklahoma City,OK 73105-3407

Print Form