Mail completed form to:
30-30 47th Avenue, 10th Fl
Long Island City, NY 11101

INSTRUCTIONS FOR MEMBERS FILING FOR DISABILITY RETIREMENT

Please follow these instructions carefully. They are designed to ensure that your application will be processed promptly.

- **Please check the application packet to see that all of the following forms are included:**
  - Application for Accident Disability Retirement or Application for Ordinary Disability Retirement
  - Applicant's Personal Report of Disability
  - Physician's Report of Disability
  - General Authorization For Medical Information
  - Disability Questionnaire

- Make sure that the application is acknowledged before a Notary Public or Commissioner of Deeds before it is mailed to NYCERS. If you are submitting the application in person you will not have to have it notarized if you can show a job identification card (picture).

- Have the Physician's Report of Disability filled out by the physician who has been treating you for the disabling condition. We have included three copies of this form, in case you have been treated by more than one physician. Please note that you must complete the authorization at the bottom of the form.

- The Applicant's Personal Report of Disability must contain the names of all hospitals, medical groups and physicians that have treated you for the disabling condition.

- A separate General Authorization for Medical Information must be completed for each hospital and medical group listed on the Applicant's Personal Report of Disability form as having treated you for your disabling condition. Hospitalization information should include the dates of admission and discharge and your hospital number.

- If you have any questions concerning these instructions, please call the Medical Division.

Please read carefully: It is your responsibility to:

1. Submit all current medical evidence to support the claim for disability retirement at least 10 days prior to the date you will be given an appointment to appear before the Medical Board. We will request medical evidence on your behalf from a hospital or H.I.P. center (not personal physicians). We cannot schedule you to come before the Medical Board until we have the required medical evidence. If the evidence is not received timely, your application could be officially suspended or closed, and you may not be eligible to reapply for disability retirement depending on your employment status.
2. Submit all X-Rays, CT Scans, MRI Films, and reports by the appointment date.
3. (For Tier 3 and Tier 4 members with Tier 3 rights only) Submit proof of filing for a Primary Social Security Disability Award within 60 days of applying for disability retirement with NYCERS. See the application for details.
4. Provide (if you are approved for Accident Disability Retirement or a Line-of-Duty Disability Retirement, except Uniformed Sanitation members) a recent Workers' Compensation Notice of Decision when you submit your option selection forms. If you are not receiving Workers' Compensation benefits, you must submit a statement from the Workers' Compensation Board regarding the status of your case. We cannot finalize payment of your disability benefits until we have this information.
5. Notify this office immediately if you plan to have surgery for the illness/injury for which you are applying for disability retirement. We will schedule you to appear before the Medical Board (if you submit the required medical evidence) prior to the surgery since the Medical Board will not be able to examine you for this illness/injury until six months after the surgery. **If you do not appear for this examination, you must submit proof that you were medically unable to do so. Failure to provide this proof will result in the suspension or closure of the application and depending on your employment status, you may not be eligible to re-apply for disability retirement. Please bear in mind that you will have to be examined by the NYCERS Medical Board before a determination can be made on your application for disability retirement**.

Please note: Should you apply for and receive a return of your accumulated salary deductions your membership will terminate and your application will not be processed.

NYCERS USE ONLY **F625**

Mail completed form to:
30-30 47th Avenue, 10th Fl
Long Island City, NY 11101

Application for Disability Retirement
22-Year Plan Members

This application is for 22-Year Plan members who are applying for Disability Retirement. Complete this form in its entirety, sign it, have it notarized, and send it to NYCERS at the mailing address above. If you wish to file this form in person, visit our Customer Service Center on the Mezzanine level of 340 Jay Street in downtown Brooklyn. If you have any questions regarding this form, please contact our Call Center at (347) 643-3000. **NOTE: If the address you provide on this form is different from your address in our system, the new address will become your official address in our records.**

Withdrawal of Application: Provided that NYCERS' Medical Board has not yet finalized its findings, you may withdraw your application for disability retirement upon written request to NYCERS. You must also complete and submit Form # 619 to NYCERS. **You may not withdraw an application filed by your agency on your behalf.**

Social Security and Workers' Compensation Offsets: Disability retirement benefits are subject to an offset of 50% of the Primary Social Security Disability Benefit or Primary Social Security Benefit, and 100% of Workers' Compensation payments for any injury.

If you are approved for Disability Retirement, no advance (partial) pension payment will be sent to you until NYCERS has acceptable proof of your birthdate on file.

In addition to this application, you must also submit (to NYCERS' Medical Board):

- Applicant's Report of Personal Disability (Form #605)
- Physician's Report of Disability (Form #606)
- General Authorization for Release of Medical Information (Form #608)
- NYCERS Questionnaire (Form #609)

Select a Benefit:

I am applying for (check all that apply):

☐ Ordinary Disability Retirement (RSSL §506)

☐ Accidental Disability Retirement (RSSL §507)

List your Disabling Conditions:

The conditions listed on this form are the **only** conditions the Medical Board will consider under this application.

Member Number	Last 4 Digits of SSN	Home Phone Number	Work Phone Number
		( )	( )

First Name	M.I.	Last Name

Address	Apt. Number

City	State	Zip Code

Title

Agency

Select a Temporary Option

This application allows you to select a temporary option, which determines what will happen to your benefit if you should die before the date of your first full payment (the "Interim Period"). If you select either the 100% Joint-and-Survivor or the Ten-Year Certain option, you must name a beneficiary. If you die before selecting an option, or if you fail to name a beneficiary, **NO DEATH BENEFIT WILL BE PAYABLE FROM NYCERS.** If you wish to select an option other than the two provided on this form, please contact our Call Center at (347) 643-3000.

NYCERS USE ONLY **F625**

Mail completed form to:
30-30 47th Avenue, 10th Fl
Long Island City, NY 11101

Member Number	Last 4 Digits of SSN

Please read the descriptions below before choosing only one temporary option. If you choose the Maximum Retirement Allowance, do not name a beneficiary. Use your beneficiary's given name (Mary Smith, not Mrs. John Smith). Note: You may not name your Estate for either the Joint-and-Survivor or the Ten-Year Certain benefit.

- **If you choose the 100% Joint-and-Survivor Option**, you may designate only one beneficiary. Under this option, NYCERS requires proof of birthdate for your beneficiary as well as additional valid documentation, such as a marriage certificate(s) for all names that your beneficiary has been known by that are different from the name on the birthdate evidence you submit.
- **If you choose the Ten-Year Certain Option**, you may designate one primary and one contingent beneficiary, and birthdate evidence for your beneficiary is not required.

CHOOSE ONLY ONE OPTION:

☐ **Maximum**

I elect to receive the maximum lifetime retirement allowance payable to me. I understand that all payments cease upon my death, and that under this option I cannot elect a beneficiary.

--OR--

☐ **100% Joint-and-Survivor**

This temporary option provides your designated beneficiary with a lifetime benefit if you die during the Interim Period. The benefit is calculated as if you had elected the 100% Joint-and-Survivor Option as your permanent option. Among the factors considered in the calculation are the life expectancies of both you and your designated beneficiary. Under this option, you receive a reduced pension (a pension lower than the Maximum Retirement Allowance) because the same amount is to be paid over two lifetimes. In this case, the benefit payable to your beneficiary for his or her lifetime would be 100% of the reduced pension you would have received during your lifetime.

The beneficiary whom I wish to nominate to receive the 100% Joint-and-Survivor benefit is:

Joint-and-Survivor Beneficiary

First Name	M.I.	Last Name

Full Social Security Number	Date of Birth [MM/DD/YYYY]	Relationship
	/ /	

Address	Apt. Number

City	State	Zip Code

☐ If this beneficiary is a minor, check here and submit Form #137. If Form #137 is not submitted, NYCERS requires Letters of Guardianship for the Estate of the minor in order to pay a benefit to the minor.

--OR--

☐ **Ten-Year Certain**

This temporary option provides that a benefit will be paid for 10 years if you die during the Interim Period. The benefit is calculated as if you had elected the Ten-Year Certain Option as your permanent option. Unlike a Joint-and-Survivor Option, the benefit payable under the Ten-Year Certain Option is not based on life expectancies, but rather on a defined period of time. Under this option, you receive a reduced pension (a pension lower than the Maximum Retirement Allowance) because the same amount continues for the remainder of the 10-year period upon your death. In this case, the benefit payable to your primary beneficiary is the same reduced pension you would have received during your lifetime. Should a primary beneficiary die after receiving payments, the balance will be paid in a lump sum to your contingent beneficiary. If none exists, the lump-sum balance is paid to the Estate of the primary beneficiary.

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Mail completed form to:
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Long Island City, NY 11101

Member Number | Last 4 Digits of SSN

The beneficiary(ies) whom I wish to nominate to receive the Ten-Year Certain benefit is:

Ten-Year Certain Primary Beneficiary

First Name | M.I. | Last Name

Full Social Security Number | Date of Birth [MM/DD/YYYY] | Relationship

Address | Apt. Number

City | State | Zip Code

☐ If this beneficiary is a minor, check here and submit Form #137. If Form #137 is not submitted, NYCERS requires Letters of Guardianship for the Estate of the minor in order to pay a benefit to the minor.

Ten-Year Certain Contingent Beneficiary

First Name | M.I. | Last Name

Full Social Security Number | Date of Birth [MM/DD/YYYY] | Relationship

Address | Apt. Number

City | State | Zip Code

☐ If this beneficiary is a minor, check here and submit Form #137. If Form #137 is not submitted, NYCERS requires Letters of Guardianship for the Estate of the minor in order to pay a benefit to the minor.

Federal Tax Withholding

Federal tax law provides that all payers are required to withhold Federal income tax on periodic payments (similar to wages), unless you elect to be excluded from such withholding. This election will remain in effect until revoked by you. If you do not complete this election, Federal income tax will be withheld at the rate of a married individual claiming three exemptions.

Please indicate your withholding selection by marking the appropriate choice below:

1. ☐ Do not withhold Federal income tax from my pension. (Do not complete 2 or 3 if you select this option)

2. ☐ Withhold based on ☐ number of exemptions using the following status (You **may** also enter a dollar amount in choice 3):

(Check one only) ☐ Single ☐ Married ☐ Married, but withhold at higher "Single" rate

3. ☐ In addition to the amount withheld based on my exemptions and filing status in choice 2,
I would like to withhold $ ☐ per month (Must specify dollar amount only).

Note: You cannot enter an amount here without entering a number of exemptions in choice 2 (even if that number is zero).

NYCERS USE ONLY **F625**

Mail completed form to:
30-30 47th Avenue, 10th Fl
Long Island City, NY 11101

Member Number	Last 4 Digits of SSN

I, the undersigned, request to apply for Disability Retirement under the disability section(s) I marked on page 1.

Signature of Member	Date

This form must be acknowledged before a Notary Public or Commissioner of Deeds

State of _____ County of _____ On this ____ day of _____ 2 0____, personally appeared before me the above named, _____, to me known, and known to me to be the individual described in and who executed the foregoing instrument, and he or she acknowledged to me that he or she executed the same, and that the statements contained therein are true.

If you have an official seal, affix it

Signature of Notary Public or Commissioner of Deeds _____

Official Title _____

Expiration Date of Commission _____

TERMS

This application must be filed by you, or by a person with legal authority to act on your behalf, or by the head of the agency where you are employed.

Note: If you apply for benefits under ARTICLE 14 you will be required to submit proof to NYCERS within 60 days of the date of this application that you have applied for primary Social Security disability benefits. NYCERS will hold your application open for a maximum of two years pending a Social Security disability award (extended by any time necessary to complete any and all appeals.) If you receive a primary Social Security disability award, you must notify NYCERS within the shorter of:
1. sixty days after the date of the award, **OR**
2. the two-year period described above, as extended by any appeals.

Ordinary Disability under RSSL §506 of Article 14
1. You must have joined NYCERS on or after April 1, 2012.
2. You have at least five years of service credit. However, all continuous public service immediately prior to joining NYCERS will be counted towards this five-year requirement.
3. You must file this application during a pay period for which you were entitled to a regular paycheck for your City service or if you were on an authorized medical leave for up to 2 years.
4. You must be found eligible to receive primary Social Security disability benefits.

If you do not follow these procedures, you will not be eligible to receive disability benefits under Article 14.

Accidental Disability Retirement Benefits Under RSSL §507 of Article 14
1. You must have joined NYCERS on or after April 1, 2012.
2. You must have been disabled as a result of an accidental injury which was sustained in the performance of your duties while a member of NYCERS, and such accident must not have been as the result of your own willful negligence.
3. You must file this application during a pay period for which you are entitled to a regular paycheck for your City service or if you were on an authorized medical leave for up to 2 years.
4. You must be found eligible to receive primary Social Security disability benefits, or be found disabled by NYCERS' Medical Board.

If you do not follow these procedures, you will not be eligible to receive disability benefits under Article 14.

NYCERS USE ONLY **F605**

Applicant's Report of Personal Disability

Please return with member's application for disability retirement.

Membership Number	Last 4 Digits of SSN	Date of Birth [MM/DD/YYYY]
		/ /

First Name	M.I.	Last Name

Address	Apt. Number

City	State	Zip Code

To NYCERS' Medical Board:

I, the undersigned, believe that I am incapacitated for further service as a

Title

in the Department of

because

I am being treated for this condition by the following doctor(s):

Name of Doctor(s) and Addresses

Note: The Physician's Report of Disability must be completed by each doctor listed above and submitted with your application

I have been hospitalized and/or treated for this condition at the following hospital(s) and/or medical group(s):

Name of Hospital(s) and/or Medical Group(s) and Addresses	**Treatment Dates [MM/DD/YYYY]**
	/ /
	/ /
	/ /

Note: An appropriate authorization for release of medical information must be completed for each hospital and/or medical group listed above, and submitted with your application

I will appear before NYCERS' Medical Board at 340 Jay Street, Mezzanine Level, in downtown Brooklyn when necessary for me to be examined.

Note: If you are unable to appear before NYCERS' Medical Board for examination, please forward your physician's certificate stating why.

Signature of Member	**Date**

Client Services 340 Jay Street Brooklyn, NY 11201 (347) 643-3000 **www.nycers.org** **Mailing Address** 335 Adams Street, Suite 2300 Brooklyn, NY 11201-3724

NYCERS USE ONLY **F606**

Physician's Report of Disability

To be returned to NYCERS with member's application for disability retirement

To NYCERS' Medical Board:

This is to certify that

First Name	M.I.	Last Name

an employee in the New York City Department of

is under my care for the following:

Diagnosis: (Clinical problem and duration)

If caused by an accident: (Type, Place and Date)

Date [MM/DD/YYYY] / /

When, if ever, may he or she return to the full duties of his or her title? Date [MM/DD/YYYY] / /

Objective evidence:
X-Rays, EKG (Photocopies), Laboratory Reports, Pertinent physical findings, Consultant Reports, Hospital Reports, Etc.

Subjective evidence:
Symptoms, Complaints, Etc.

Treatment and result:

Client Services 340 Jay Street Brooklyn, NY 11201 (347) 643-3000 **www.nycers.org** **Mailing Address** 335 Adams Street, Suite 2300 Brooklyn, NY 11201-3724

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Member Number | Last 4 Digits of SSN

Physician First Name | Physician Last Name | Title (MD, DO, DC etc.)

Address | Apt. Number

City | State | Zip Code

Signature of Physician | **Date**

Applicant's Authorization for Release of Information

Dear Doctor _____, you are hereby authorized by me to fill out this form for the information of the Medical Board of the New York City Employees' Retirement System.

Signature of Applicant | **Date**

First Name | M.I. | Last Name

in Care of (if applicable) | Full Social Security Number

Address | Apt. Number

City | State | Zip Code

NYCERS USE ONLY **F608**

General Authorization for Medical Information

This form authorizes NYCERS to obtain medical information pertaining to those filing for disability. NYCERS understands that information about your health is personal and we are committed to protecting your privacy. Please be sure you understand how NYCERS will use your medical information prior to signing this form. Should you have any questions, please contact our Call Center at 347-643-3000.

Member Number	Last 4 Digits of SSN	Date of Birth [MM/DD/YYYY]
		/ /

First Name	M.I.	Last Name

Address	Apt. Number

City	State	Zip Code

Name of Hospital or Medical Group

Dates of treatment/service: [MM/DD/YYYY] / / [MM/DD/YYYY] / / [MM/DD/YYYY] / / [MM/DD/YYYY] / /

Expiration date of this authorization: [MM/DD/YYYY] / /

Please initial each of the following to state your understanding of this form.

☐ I understand that by completing this form in full, I authorize the use and disclosure of my medical records for the purpose of applying for disability retirement.

☐ I understand that this information may be re-disclosed if the recipient(s) described on this form is not required by applicable law to protect the privacy of the information and such information is no longer protected by federal health information privacy regulations.

☐ I understand that my medical records may contain information relating to Alcohol or Drug Abuse, genetic testing, psychiatric care and/or confidential HIV/AIDS related information.

☐ I understand that if I am authorizing the use or disclosure of HIV/AIDS related information, the recipient is prohibited from using or redisclosing any HIV/AIDS related information without my authorization unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS related information, I may contact New York State Division of Human Rights at 212-480-2493 or the New York City Commission of Human Rights at 212-306-7450. These agencies are responsible for protecting my rights.

☐ I have read this form and all of my questions about this form have been answered. 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 City Employees' Retirement System.

Signature of Member	**Date**

NYCERS USE ONLY **F609**

Questionnaire
Applicants for Disability Retirement

This application is to accompany your application for Disability Retirement. Please be sure you read and understand the questions asked on this form before answering. Should you have any questions, please contact our Call Center at 347-643-3000.

Member Number	Last 4 Digits of SSN

First Name	M.I.	Last Name

This section must be completed by ALL members applying for Disability Retirement.

1. What is (are) the disabling condition(s) which is (are) the basis for your applying for disability retirement?

2. Check all relevant boxes that indicate your symptoms
   - ☐ Pain ☐ Weakness ☐ Difficulty Walking
   - ☐ Weight Loss ☐ Depression ☐ Other _____

3. When did symptoms begin? [MM/DD/YYYY] / /

4. Please list the name(s), address(es) and frequency of persons and/or institutions from whom you are receiving treatment.

5. Nature of treatment, including medications being taken.

6. Check boxes below to indicate tests performed: **(Bring a copy of ALL REPORTS, if possible.)**
   - ☐ Blood and Urine ☐ X-Rays ☐ EMG (Electromyogram)
   - ☐ EKG (Electrocardiogram) ☐ Myelogram ☐ CT scan
   - ☐ Stress Test ☐ Pulmonary Function studies ☐ Pathology or Biopsy Reports
   - ☐ Other _____

7. Hospital admission(s): (Hospital Reports must be supplied to this office.)

   (A) Name of hospital(s):

   1). _____

   2). _____

Client Services 340 Jay Street Brooklyn, NY 11201 (347) 643-3000 **www.nycers.org** **Mailing Address** 335 Adams Street, Suite 2300 Brooklyn, NY 11201-3724

NYCERS USE ONLY **F609**

Member Number | Last 4 Digits of SSN

(B) Dates of admission and discharge:

1). _____

2). _____

(C) Diagnosis(es):

1). _____

2). _____

Was surgery performed? ☐ **Yes** ☐ **No** If Yes, give dates and type of surgery performed.

1). _____ [MM/DD/YYYY] / /

2). _____ [MM/DD/YYYY] / /

8. Check all relevant boxes that your job requires.

☐ **Lifting** ☐ **Working Outdoors** ☐ **Walking** ☐ **Climbing** ☐ **Other** _____

9. Do you feel that you are totally and permanently disabled from performing the usual duties of your title?

☐ **Yes** ☐ **No**

Could you do other work? ☐ **Yes** ☐ **No**

10. Are you working now? ☐ **Yes** ☐ **No**

If Not, when did you stop? [MM/DD/YYYY] / /

11. What is the name of your union, and local? _____

12. Are you receiving Social Security Disability Benefits? ☐ **Yes** ☐ **No**

13. Please give a daytime telephone number where you can be reached. ( )

14. Did you have previous service with New York City or New York State prior to your current membership?

☐ **Yes** ☐ **No**

If yes, When? [MM/DD/YYYY] / / [MM/DD/YYYY] / / [MM/DD/YYYY] / /

NYCERS USE ONLY **F609**

Member Number | Last 4 Digits of SSN

This section is to be completed ONLY by members applying for disability retirement as a result of an accidental injury during the performance of their duties while in City service.

15. What is your date of birth? [MM/DD/YYYY] / / (Attach a copy of your Birth Certificate.)

16. What was the date of the injury? [MM/DD/YYYY] / /

17. What part of your body was injured?

18. What were you doing when you were injured?

19. Were you on full duty at the time of the injury? ☐ **Yes** ☐ **No**

20. Were you performing any unusual work at that time? ☐ **Yes** ☐ **No**
If Yes, describe.

21. What is the nature of the injury?

22. How were you injured?

23. Were there any witnesses to the incident when you were injured? ☐ **Yes** ☐ **No**
If Yes, give Name, Title and Address (if known).

24. When did you stop working because of the injury? [MM/DD/YYYY] / /

25. Do you have proof of this occurrence? ☐ **Yes** ☐ **No**

26. When were you first treated for the injury referred to above, and by whom?
Date [MM/DD/YYYY] / /
By Whom?
Place?

27. State the name of medical persons or institutions who treated you for the injury described. State dates and frequency.
[MM/DD/YYYY]
Name of Person or Institution / /
Name of Person or Institution / /
Name of Person or Institution / /

NYCERS USE ONLY **F609**

Member Number | Last 4 Digits of SSN

28. Have you had any similar disability before the injury? ☐ **Yes** ☐ **No**

29. Have you had any other accidents or injuries on the job (either before or after the injury claimed herein)?

☐ **Yes** ☐ **No**

If Yes, give dates and description of injury _____ [MM/DD/YYYY] / /

_____ / /

30. Have you had any accidents or injuries off the job? ☐ **Yes** ☐ **No**

If Yes, give dates and descriptions of injury _____ [MM/DD/YYYY] / /

_____ / /

31. Did you return to full duty after the injury herein claimed? ☐ **Yes** ☐ **No**
If Yes, When? / / [MM/DD/YYYY]

32. Did you return to light duty after the injury herein claimed? ☐ **Yes** ☐ **No**
If Yes, When? / / [MM/DD/YYYY]

33. Are you being treated for any other injuries/disorders? ☐ **Yes** ☐ **No**
If Yes, describe injury/disorder and treatment.

_____

34. Do you drink alcohol regularly (one-half pint or more per-week)? ☐ **Yes** ☐ **No**
Do you drink occasionally? ☐ **Yes** ☐ **No**

If yes, how often? _____

How much? _____

35. Do you take any medications daily? ☐ **Yes** ☐ **No**

If Yes, What? _____

36. Do you use any recreational drugs? ☐ **Yes** ☐ **No**

If Yes, What and how often? _____

37. Did you file a Workers' Compensation claim? ☐ **Yes** ☐ **No**

Are you receiving Workers' Compensation payments? ☐ **Yes** ☐ **No**

38. If Yes, how much bi-weekly? _____

Signature of Member | **Date**

NYCERS USE ONLY **F615**

NYCERS NYC Employees' Retirement System

Mail Completed Forms to:
30-30 47th Avenue, 10th Fl
Long Island City, NY 11101

Authorization for Release of Information

Use this form to authorize the New York City Employees' Retirement System (NYCERS) to provide information and/or records to someone other than the NYCERS member, pensioner, or beneficiary. If you have any questions, please contact our Call Center at 347-643-3000. **NOTE: If the address you provide on this form is different from your address in our system, the new address will become your official address in our records.**

Member Number OR	Pension Number	Last 4 Digits of SSN	Phone Number

First Name	M.I.	Last Name

Address	Apt. Number

City	State	Zip Code

I, _____ , hereby authorize the New York City Employees' Retirement System (NYCERS) to provide _____ of _____
Name of Individual *Name of Entity (If Applicable)*

Address: _____ Daytime Phone: _____

(hereinafter Third Party), with the following (check one from each column if you wish):

- ☐ Any and all information **except Medical Records** regarding the NYCERS account referenced above. **- OR -**
- ☐ Specific information **except Medical Records** regarding the NYCERS account referenced above. Describe specific information below:

_____

_____

- ☐ Any and all **Medical Records** regarding the NYCERS account referenced above. **- OR -**
- ☐ Specific **Medical Records** regarding the NYCERS account referenced above. Describe specific Medical Records below:

_____

_____

I understand that NYCERS has no authority to control the future use or dissemination of any information released to the Third Party identified above. Therefore, I release NYCERS, the City of New York, and any officers, agents, or employees thereof, from any and all liability that may arise out of the Third Party's possession and/or use of the information and/or records provided pursuant to this authorization.

This authorization is effective on the date signed below, and will remain in effect until NYCERS' receipt of a written, notarized revocation from the Member/Pensioner/Beneficiary.

Signature of Member/Pensioner/Beneficiary	**Date**

This form must be acknowledged before a Notary Public or Commissioner of Deeds

State of _____ County of _____ On this ____ day of_____ 20 _____ , personally appeared before me the above named, _____ to me known, and known to me to be the individual described in and who executed the foregoing instrument, and he or she acknowledged to me that he or she executed the same, and that the statements contained therein are true.

Signature of Notary Public or Commissioner of Deeds _____

Official Title _____

Expiration Date of Commission _____

If you have an official seal, AFFIX IT