



**Municipal Employees' Annuity and  
Benefit Fund of Chicago**

*A Pension Trust Fund of the City of Chicago*  
321 N. Clark Street, Suite 700, Chicago, Illinois  
60654  
Telephone: 312 -236-4700 Fax: 312-527-0192  
[www.meabf.org](http://www.meabf.org)



Dear Member:

Enclosed are the forms you must complete and a list of required documents that you need to submit in order for us to process your application for Duty Disability benefits.

### **Forms to be completed (enclosed)**

- Authorization to Disclose Health and Employment Related Information
- Disability Application
- Letter of Acceptance
- Medical Examiner's Certificate
- Concentra Services - Patient Information
- Concentra Services - Authorization for Disclosure of Protected Health Information (PHI) HIPAA Release

### **Required documents to be returned with the forms**

Copy of Leave of Absence (LOA) approved by your department

### **Important Information**

- In order to begin the processing of your disability benefits, your application must be **complete** and all required documentation provided.
- **Ordinary Disability benefits do not cover you for 30 days of disablement.**
- **Upon the Fund's receipt of your completed Disability application and medical form, you are required to make an appointment with a local Concentra provider for approval of this benefit. This should only be done once we have your completed application back in our office. Therefore, please be sure to list an active phone number and email address on the application.**
- If you become separated from service for any reason, or are released to return to work, or return to work while receiving disability benefits, you are required to notify this Fund immediately.
- Disability payments are paid while you are disabled and while you are an employee of the City of Chicago or Board of Education. If you become terminated or if you resign, all disability payments stop. If payments are made after such date in error, they will be deducted from any benefits we pay you.

**Enclosed please find a listing and map of all Chicago Concentra locations. If you are physically unable to appear at any of these locations, kindly notify the Fund.**

If you have any questions regarding the application process or your disability benefits, please contact Scott Walters at (312) 236-4700 Ext 2123.

Disability Department

Additional information regarding disability benefits can be found on our website at [www.meabf.org](http://www.meabf.org)



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## Authorization to Disclose Health and Employment Related Information

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Name of Member (First Name, Middle Initial, Last Name)

Last 4 digits Social Security Number or MEABF ID#

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Daytime Phone Evening Phone

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Address

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City State ZIP

### Authorization to Release Information

I authorize the disclosure of my protected health information, including but not limited to, medical histories, diagnoses, examination reports, chart notes, testing and test results, X-rays, operative reports, lab and medication records, prescriptions, and any other records relating to the prognosis, treatment or diagnosis of any physical, mental, psychological or psychiatric condition, to the Municipal Employees' Annuity and Benefit Fund of Chicago (MEABF) or its representative, for the sole purpose of determining my physical or mental condition, illness, or disability and my right, if any, to benefits under the Illinois Pension Code (40 ILCS 5/8 et seq). I understand that any information about me disclosed pursuant to this Authorization will be used by MEABF for the administration of its duties under the Illinois Pension Code. I understand that this Authorization and submission of the requested information is authorized pursuant to Section 8-162 and Section 8-163(a) of the Illinois Pension Code and that failure to supply the information requested may result in MEABF being unable to make a determination regarding my benefit status.

This Authorization applies to any and all health and/or medical related information about me in the possession of any health care provider, health plan, insurance company, employer or plan administrator, government agency, or organization or entity administering a benefit program.

I understand that if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, that information may be re-disclosed and would no longer be protected.

I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing by a letter directed to the MEABF Disability Department. I am aware that my revocation is not effective to the extent that persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization. Unless cancelled by me in writing, this Authorization shall be valid for four (4) years from the date shown below. A photocopy of this Authorization shall be as valid as the original. I understand that I may request a copy of this Authorization at any time.

I also authorize the disclosure of any and all personnel and other employment-related records on file with any of my present or future employers which relate to my job duties, work performance, and other work-related issues including, but not limited to, attendance and sick leave records and records of administrative and judicial action arising out of, or related to, my past and present employment. I understand that it is my responsibility to notify the MEABF if I have returned to work, or have left the employment of my employer. I also understand that I must notify MEABF if I assume other employment while in receipt of a disability benefit in accordance with Section 8-163(d).

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Signature of Member

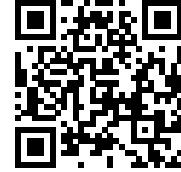
Date (mm/dd/yyyy)

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Email Address of Member



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**OFFICE USE ONLY – Payment**

Start Date	End Date	Daily Rate

**APPLICATION FOR DISABILITY BENEFITS - ORDINARY**

(FOR DISABILITY THAT IS **NOT** A RESULT OF AN INJURY INCURRED IN THE PERFORMANCE OF DUTY)

**SECTION 1 – MEMBER INFORMATION**

(Please Print or Type)

NAME (FIRST, MI, LAST)		DATE OF BIRTH (MM- DD- YYYY)	SOCIAL SECURITY NUMBER (LAST 4 DIGITS)
ADDRESS			CITY, STATE, ZIP
PRIMARY PHONE NUMBER ( )	SECONDARY PHONE NUMBER ( )		E-MAIL ADDRESS
JOB TITLE		DEPARTMENT	
EMERGENCY CONTACT (FIRST, MI, LAST)			EMERGENCY CONTACT PHONE NUMBER ( )

**SECTION 2 – NATURE OF DISABILITY**

LAST DAY WORKED DUE TO DISABILITY (MM- DD- YYYY)	LAST DATE PAID (MM- DD- YYYY)
HAVE YOU BEEN RELEASED TO RETURN TO WORK? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, DATE (MM-DD-YYYY) _____	
DESCRIBE ACCIDENT / ILLNESS THAT CAUSED DISABILITY	

**SECTION 3 – FEDERAL TAX WITHHOLDING ELECTION**

(ORDINARY DISABILITY BENEFITS ARE TAXABLE INCOME)

(Please complete only **one** of the following)

- 1)  I do not want Federal income tax withheld from my payment.
- 2)  I want to have Federal income tax withheld from my payment based on the elections I have indicated below:  
 Single  Married With # of Exemptions \_\_\_\_\_ (If you do not indicate # of Exemptions, we will process with 1 Exemption)
- 3)  I want the following EXACT amount of Federal income tax withheld each month from my payment \$ \_\_\_\_\_

**SECTION 4 – CERTIFICATION**

I authorize the Municipal Employees' Annuity and Benefit Fund of Chicago to have access to all records needed to Properly process this application.

**MEMBER SIGNATURE X** \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

**WITNESS SIGNATURE X** \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

PRINT WITNESS NAME \_\_\_\_\_ PHONE NUMBER (\_\_\_\_) \_\_\_\_\_

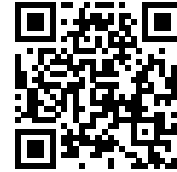
Be advised that under Illinois law (P.A. 97-0651) MEABF is required to report to the state's Attorney for investigation any reasonable suspicion of any falsified statement or record or any fraudulent claim involving the MEABF. Under State law a person convicted of fraud may be subject to a fine of not more than \$25,000 or imprisonment for not more than five (5) years or both.

**ORIGINAL DOCUMENT REQUIRED. DO NOT FAX**



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 Dennis White, Executive Director



OFFICE USE ONLY

Start Date	Last Ext. Date	Daily Rate

Ext

**MEDICAL EXAMINER'S CERTIFICATE FOR DISABILITY BENEFITS - ORDINARY**

**SECTION 1 – TO BE COMPLETED BY EMPLOYEE** (Please Print or Type)

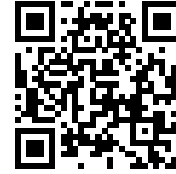
NAME (FIRST, MI, LAST)		DATE OF BIRTH (MM-DD-YYYY)	SOCIAL SECURITY NUMBER (LAST 4 DIGITS)
JOB TITLE		DEPARTMENT	
DESCRIPTION OF DUTIES			
MEMBER SIGNATURE X _____			DATE ____ / ____ / ____

**SECTION 2 – TO BE COMPLETED BY PHYSICIAN**

In an effort to ensure appropriate eligibility for disability benefits, we are evaluating the medical evidence and related information on the above patient. Please assist us by completing, signing, and returning the following information to the Fund office. <b>THE FOLLOWING REQUESTED INFORMATION MUST BE COMPLETED IN ITS ENTIRETY OR THE FORM WILL BE RETURNED FOR PROPER COMPLETION. (We do not accept faxes or copies of this form. Original form must be returned.)</b>			
DATE OF MOST RECENT EXAM		DATE OF INITIAL EXAM	
DIAGNOSIS			
HOW DOES THIS DIAGNOSIS PROHIBIT THE PATIENT FROM PERFORMING THE DUTIES OUTLINED IN THE THEIR DESCRIPTION OF DUTIES?			
ARE THERE ANY OTHER FUNCTIONAL LIMITATIONS OR PHYSICAL RESTRICTIONS IMPEDING THE PATIENT'S ABILITY TO PERFORM HIS OR HER DUTIES?			
IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
IF SURGERY IS/WAS NECESSARY, SURGERY DATE ____ / ____ / ____ TYPE OF SURGERY:			
IF <u>ORDINARY DISABILITY</u> IS DUE TO PREGNANCY, DUE DATE ____ / ____ / ____ LIST COMPLICATIONS RELATED TO PREGNANCY:			
TREATMENT PLAN			
IS PATIENT NOW ABLE TO RETURN TO WORK IN FULL DUTY CAPACITY OR WITH WORK RESTRICTIONS? <input type="checkbox"/> YES, FULL DUTY <input type="checkbox"/> YES, WITH RESTRICTIONS    IF YES, DATE ____ / ____ / ____ <input type="checkbox"/> NO    IF NO, ESTIMATED DURATION OF DISABILITY _____			
PHYSICIAN NAME (FIRST, MI, LAST)		DEGREE / SPECIALTY	
ADDRESS		CITY, STATE, ZIP	
PHONE NUMBER (     )		FAX NUMBER (     )	
I hereby certify that the information provided above is true and accurate to the best of my knowledge.			
PHYSICIAN SIGNATURE X _____			DATE ____ / ____ / ____



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## Application for Ordinary Disability – Letter of Acceptance

Name:

SSN:

In submitting this application for Ordinary Disability benefits I am stating that the occurrence that has led to my disablement was **not the result** of an injury incurred in the performance of my employment duties (Duty Disability). I understand that I may not file an application for Ordinary Disability if:

- 1) I have filed a claim for Workers' Compensation benefits from my employer.
- 2) I have been denied Workers' Compensation benefits from my employer and I am disputing the ruling.
- 3) I have filed for Duty Disability benefits with the Fund and have not rescinded my application.

By signing this application I am stating that my disability is the result of any cause other than injury incurred in the performance of duty (40 ILCS 5/8-161). If at a later date I state that it is an injury incurred in the performance of duty, then I am aware I subject myself to:

- 1) Immediate stoppage of Ordinary Disability benefits.
- 2) Repayment of all benefits received relating to this Ordinary Disability application.
- 3) Payment of interest on the benefits received.
- 4) Accusation of Fraud (40 ILCS 5/1-235). Any person who knowingly makes any false statement or falsifies or permits to be falsified any record of a pension fund created under this Code in an attempt to defraud the pension fund created under this Code is guilty of a Class 3 felony. The Retirement Board shall immediately notify the State's Attorney where any alleged fraudulent activity occurred for investigation.

By signing this letter, I state that I have read and understand the requirements of filing an application for Ordinary Disability benefits and that I am fully aware of the actions that the Fund must take if it is determined that I fraudulently applied for these benefits.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name



**Employer Services-Authorization For Disclosure of Protected Health Information (PHI) HIPAA Release**

I authorize Concentra to use and disclose protected health information (PHI) from the record(s) of:

Patient's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

**Purpose of Disclosure**

- Occupational Injury
- Occupational Non-Injury
- Other

**Confirmation of Who May Receive Copies of Your Records**

Employer or Entity Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Confirmation Telephone Number: \_\_\_\_\_

**In Connection With This Authorization:**

- I am aware that copies of records for services rendered on \_\_\_\_\_ (date of service) and subsequent related visits containing PHI which may include the results of tests or evaluations, including diagnosis, medical history, transcription notes, tests; and evaluations performed that my treating clinician(s), employer, prospective employer or third-party entity has ordered or requires.
- I give Concentra authorization to release to my employer, insurance company, and/or their representatives any medical information, including any psychotherapy notes, psychiatric information, sexually transmitted diseases, alcohol, and drug abuse (;) and/or HIV/
- AIDS status, which is obtained as part of the evaluation and/or treatment for this work-related injury/illness, or employment-related examination.
- I understand that if the person or entity that receives the above information Is not a health care provider or health plan covered by federal privacy regulations, the Information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that I may revoke this authorization at any time, except to the extent that action has already been taken by Concentra, by providing a written request to the Center where my care was provided.
- I understand that Concentra may not deny treatment If I do not complete this authorization form but may deny services when the services are only to create PHI for disclosure to a third party.
- I have a right to not sign this authorization or to limit the information I authorize to be disclosed to the minimum necessary, however, refusal to sign this authorization or to limit disclosure of my PHI may violate a condition of employment or prospective employment.
- I may revoke this authorization at any time, but I must do so by submitting a written notice to the Concentra center where I received services. However, if I am here for a work-related visit that is subject to Workers' Compensation, under some state laws I am not allowed to revoke this authorization.
- I understand that this authorization expires one year from the date of execution, unless revoked in writing, or a shorter expiration date Is required by applicable state law.

I have a right to receive a copy of this authorization.

\_\_\_\_\_  
Signature of Patient's Representative/Date: \_\_\_\_\_ OR \_\_\_\_\_  
Patient's Signature/Date: \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Patient's Representative Explanation of your legal right to sign for Patient

For HIPAA questions related to this form, please contact the Concentra Privacy Office at 1-800-819-5571

Privacy-Occupational Authorization-ENG 032421



## Employer Services Patient Information

### About You

#### Reason for Today's Visit

Injury care  Physical exam  DOT (CDL) certification  Drug screen  Other: \_\_\_\_\_

Social security number or Military DBN \_\_\_\_\_ Date of birth (MM/DD/YYYY): \_\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_

Address: \_\_\_\_\_ Apartment number: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

**Birth Sex:**  Male  Female      **Gender:**  Male  Female  Non-binary       Single  Married

Email address: \_\_\_\_\_ Concentra may send a detailed email:  Yes  No

For security of your records, all emails containing protected health information (PHI) are sent encrypted,

**\* Consent to Receive Text Messages:** By providing your personal cell phone number to Concentra, you are agreeing to receive text messages from Concentra, its related companies, and/or vendors regarding medical services. Your consent to receive such communication is not a condition of the provision of medical services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### About Your Employer

#### Employer Requesting Services

Company name: \_\_\_\_\_ Location/store number: \_\_\_\_\_

Address: \_\_\_\_\_ Suite number: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Is your employment arranged through a temporary hire agency?  Yes  No

Name of agency: \_\_\_\_\_ Agency phone: \_\_\_\_\_

### Notice of Privacy Practices

Your name and signature below indicates that you have been made aware of Concentra's Notice of Privacy Practices (NOPP) on the date indicated. You understand that the NOPP is posted in the center and a copy will be provided to you if you request it. If this is your first date of service with Concentra, please indicate this to the front desk receptionist and he/she will provide you a copy of the NOPP. If you have any questions regarding the information in Concentra's Notice of Privacy Practices, contact Concentra's Privacy Office at 800-819-5571 or [privacyoffice@concentra.com](mailto:privacyoffice@concentra.com).

Name: (please print) \_\_\_\_\_ Date notice received: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Consent

Please read and sign both sections below UNLESS you are here for a Department of Transportation drug screen or breath alcohol test only (no physical).

The information provided is correct to the best of my knowledge I will not hold Concentra, its health provider, or its employees responsible for any errors or omissions that I may have made in completing the information on this form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I give permission to Concentra to perform the following services that the physicians and other non-physician providers and assistants may deem to be necessary: (a) medical, surgical, and diagnosis (e.g., including but not limited to x-rays, blood draws, and laboratory tests) processes, treatments, and procedures; (b) administration of injections, medications, and immunizations (with immunizations to occur after my receipt of any applicable vaccine information statements ("VIS" or "VISs")); and (c) completion of medically appropriate tests for communicable and other diseases; and (d) completion of a pelvic examination, if medically appropriate. I further understand that by counseling to receive a vaccine, I am authorizing Concentra to release my immunization information to the applicable state immunization registry.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# CHICAGO LOCATIONS

## 1. Bedford Park

5015 W 65th St  
Bedford Park, IL 60638  
Mon-Fri: 8 am -5 pm  
Ph: 708.924.8000  
Fx: 708.924.8008

## 2. Bellwood

2615 W. Harrison St.  
Bellwood, IL 60104  
Mon - Fri: 7 am - 7 pm  
Ph: 708.493.0299  
Fx: 708.493.0594

## 3. Bloomingdale

211 E. Army Trail Rd.  
Bloomingdale, IL 60108  
Mon-Fri: 7 am - 8 pm  
Ph: 630.582.8946  
Fx: 630.582.0969

## 4. Bridgeview

8755 S. Harlem Ave.  
Bridgeview, IL 60455  
24 Hours, 7 Days a Week  
Ph: 708.430.2295  
Fx: 708.430.2372

## 5. Chicago Ashland Ave

(Ashland Ave at 1-55)  
3145 S. Ashland Ave.  
Suite 110  
Chicago, IL 60608  
Mon - Fri: 7 am -10 pm  
Ph: 773.254.5516  
Fx: 773.254.5518

## 6. Chicago Downtown

614 W. Monroe St.  
Chicago, IL 60661  
Mon - Fri: 8 am - 5 pm  
Ph: 312.258.0700  
Fx: 312.258.0705

## 7. Chicago Midway

6500 West 65th St.  
Chicago, IL 60638  
Mon - Fri: 7am - 7 pm  
Ph: 708.496.1515  
Fx: 708.496.3433

## 8. Chicago Pullman District

900 E. 103rd St.  
Chicago, IL 60628  
Mon - Fri: 8 am -5 pm  
Ph: 773.468.2963  
Fx: 773.468.2975

## 9. Chicago River West

1030 W. Chicago Ave.  
Chicago, IL 60642  
Mon - Fri: 7 am- 10 pm  
Sat: 8 am - 5 pm  
Ph: 312.243.1574  
Fx: 312.243.1698

## 10. Chicago West Loop

1230 W. Lake St.  
Chicago, IL 60607  
Mon - Fri: 8 am - 5 pm  
Ph: 312.666.0028  
Fx: 312.666.5214

## 11. Darien

7421 South Cass Ave.  
Darien, IL 60561  
Mon- Fri: 8 am- 8 pm  
Ph: 630.286.5300  
Fx: 630.986.1096

## 12. Elk Grove Village

1830 Jarvis Ave.  
Elk Grove Village, IL 60007  
Mon - Fri: 8 am -5 pm  
Ph: 847.952.1180  
Fx: 847.952.1183

## 13. Franklin Park

10137 W. Grand Ave.  
Franklin Park, IL 60131  
Mon - Fri: 7 am-10 pm  
Sat: 8 am - 5 pm  
Ph: 847.451.7590  
Fx: 847.451.7608

## 14. Hammond

6423 Columbia Ave, U  
Hammond, IN 46320  
Mon-Fri: 7 am- 8pm  
Ph: 219.937.3632  
Fx: 219.937.4715

## 15. Morton Grove

8125 River Dr.  
Suite 102  
Morton Grove, IL 60053  
Mon - Fri: 8 am - 5 pm Ph:  
847.470.1720  
Fx: 847.470.1723

## 16. Schiller Park

4200 N. Mannheim Rd.  
Schiller Park, IL 60176  
Mon -Fri: 8 am -5 pm  
Ph: 847.801.5170  
Fx: 847.801.5176

## 17. Wheeling

544A W. Dundee Rd.  
Wheeling, IL 60090  
Mon - Fri: 7 am - 9 pm  
Ph: 847.419.6974  
Fx: 847.419.6982

- Work-related injuries receive immediate triage assessment.
- Pre-placement and DOT exam forms are provided, or you may use other DOT approved MER and/or MEC forms.
- No contract is required when working with Concentra. Our fees are competitive and adhere to the applicable state workers' compensation fee guidelines.
- Visit [concentra.com/our-locations](http://concentra.com/our-locations) for a list of locations and driving directions



