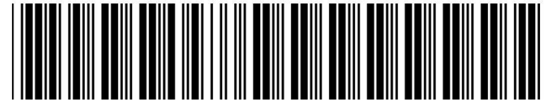

Form 8002
Revised 09/2024

Certification of Application for Disability Retirement and Supporting Medical Information

Member Information	
Member Name:	Member ID:

Beneficiary Information			
Beneficiary Name:	SSN:		
KPPA will update contact information for your retirement account based on the details provided below.			
Address:	City:	State:	Zip Code:
Phone (select type) ☐ Mobile ☐ Home ☐ Work	Email:		

As beneficiary of the above member's account, I, ______________________________ , hereby certify that the attached medical information, job description, reasonable accommodations request, and prescription and nonprescription drug list are true, correct, accurate, and complete. I am aware that pursuant to KRS 61.665(2)(a) and 78.545, I am responsible for filing supporting objective medical information to report the deceased member's physical and mental condition prior to death. The attached objective medical information consists of all existing medical records regardless of the above member's membership date with the Kentucky Public Pensions Authority. Written statements by medical providers alone are not objective medical information unless accompanied by supporting records as discussed in this paragraph. I hereby certify that the application for disability retirement, medical information, and job description are ready to be submitted to the medical examiners for review and determination. I am aware that by signing this certification I am certifying to the Kentucky Public Pensions Authority that the enclosed medical records represent all of the above member's evaluations, examinations, and treatment for the condition(s) for which the member was applying for disability retirement benefits, including all reports of diagnostic medical testing performed on the above member.

I acknowledge that I have full understanding that any person who provides a false statement, report, or representation to a governmental entity such as KPPA is subject to the penalty of perjury in accordance with KRS 523.010, et seq. I further acknowledge that if I knowingly submit or cause to be submitted a false or fraudulent claim for the payment or receipt of benefit, I may be liable for repayment of benefits I was not entitled to receive, but also liable for civil payments, legal fees, and costs.

Beneficiary's Signature: ______________________________ Date: ____________________