KENTUCKY PUBLIC PENSIONS AUTHORITY
1260 Louisville Road • Frankfort, KY 40601
Phone: (502) 696-8800 • Fax: (502) 696-8822 • kyret.ky.gov

Print Form

Form 8001
Revised 09/2024

Certification of Application for Disability Retirement and Supporting Medical Information

Member Information

Member Name:	Member ID:

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:

Certification

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. This means the attached information consists of all the existing medical information regarding the condition(s) for which I am seeking enhanced disability retirement benefits. The medical information includes all existing medical records regardless of the membership date with Kentucky Public Pensions Authority. I further hereby certify that my 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 pursuant to KRS 61.665(2)(a) that I am responsible for filing supporting objective medical information to report my physical and mental condition. Written statements by medical providers alone are not objective medical information unless accompanied by supporting records as discussed in this paragraph. I am also aware that by signing this certification I am certifying to Kentucky Public Pensions Authority that the enclosed medical records represent all the evaluations, examinations, and treatment I have had for the condition(s) for which I am applying for disability retirement benefits, including all reports of diagnostic medical testing performed on me.

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.

Signature: _____ Date: _____