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ADDENDUM TO APPLICATION FOR DISABILITY RETIREMENT BENEFITS

Member Name:

Prefix First MI Last Suffix

Date: Last Four Digits of Your Social Security Number:

About Your Medical Condition

Condition:

1. When did this condition first bother you?

2. What symptoms does this condition cause?

3. How do these symptoms interfere with your life?

4. What limitations does this condition and its symptoms cause in your ability to function?

5. How are you presently being treated for this condition, including taking any medications?

By whom? How often?

6. Is this treatment helping? Yes No Explain:

7. What restrictions has your healthcare provider put on your activities, as a result of this condition?

Healthcare Provider's Name:

When were restrictions applied?

Do you comply?

8. Have you ever sought a second opinion about this diagnosis or treatment? Yes No
 If "Yes," give healthcare provider's name and results.

9. Have you tried other treatments/medications/steps in the past? Yes No If "Yes," with what result?

10. Have you declined to try any recommendation of healthcare providers for managing or minimizing the effects of this condition? Yes No If "Yes," what has been declined and why?