Introduction
Member's Application for Disability Retirement

Updated August, 2008

Before you file an application for a disability retirement allowance, please note that you should:

- Contact your retirement board. This is an important step in ensuring that you have all of the information that you need. The staff at your retirement board will help you understand the process and respond to your questions throughout the process.

- Read the *Guide to Disability Retirement for Public Employees*. This guide will give you general information about the disability process. Your retirement board can furnish you with a copy of this guide.

Next Step

- Be sure to complete the entire application, including the release forms, and attach all required documents before returning your application to your retirement board. If your application is incomplete, the application process will be delayed. Until all of the required information has been submitted, your retirement board cannot assign a date of application, which will be very important in determining your effective date of retirement and retirement allowance date. Your retirement board can prepare an estimate of your retirement allowance for planning purposes at any time, but an official retirement allowance cannot be calculated until your application has been approved. If your application is approved, you may need to submit additional documents, including, if applicable, your marriage certificate, your spouse's birth certificate, and your dependent children's birth certificates.

- Before you send your application and your documents to your retirement board, make a photocopy of them for your own records.

Your Retirement Board Will

Request information from your employer, your personal physician, and the other physicians, hospitals, and insurance companies that you identified on your application.

- You may, if you wish, personally convey the *Physician's Statement* to your primary treating physician. If you choose to do so, let your retirement board know so that confusion and duplication of effort can be avoided.

Next Step

When all the information specified above has been received by your retirement board, the "application package" is considered complete and your retirement board will decide whether to ask the Public Employee Retirement Administration Commission (PERAC) to set up a three member regional medical panel to examine you.

Timeframes

- The regional medical panel should meet within 60 days of being appointed by PERAC to conduct its examination.

- You will be given 14 days notice of the scheduled examination.

- The regional medical panel will report their findings and recommendations to PERAC within 60 days after completing their examination(s).

- Within 5 days of receipt of a properly completed medical report, PERAC will forward the report to your retirement board.

- Within 30 days of receipt of the report, your retirement board will notify you of the panel's findings and provide you with a copy of all of the documents completed by the regional medical panel.

- Your retirement board has the option at this point of requesting further information or a clarification from the regional medical panel if they determine that it would be helpful.

- If the regional medical panel precludes retirement for the disability you claimed, your retirement board could either deny your application or it could ask PERAC for a new regional medical panel if the board believes that circumstances warrant it.

  If PERAC declines to schedule a new examination, your board will deny your application.

- If the regional medical panel findings permit retirement for the disability claimed, your retirement board shall determine whether or not to approve the application. A hearing may be held on any disability retirement application and shall be held upon your request.

- If a hearing is scheduled, your board must give you at least 30 days notice of the time and place for the hearing and the issues involved.

- Your retirement board's decision about your eligibility for disability retirement must be made no later than 180 days after you file your completed application, unless PERAC grants an extension.

- If your application is approved by your retirement board, it will be transmitted to PERAC for final action. PERAC must act on your application within 30 days of its receipt.

- If your application is denied by your retirement board, your retirement board will advise you of your right to appeal the decision.

Member's Application for Disability Retirement

Updated August, 2008 | Previously Identified as PERA 10-1, 10-3, 10-4, 10-5, 10-6 (1-3), 10-19A-792

Retirement Board: Please place your address and phone number here. ▸

Intent to Retire

Applicant's Last Name | First | M.I. | Former or Maiden Name (If different)

Street Address | xxx-xx- Social Security #

City | State | Zip | Phone #

Date of Birth | Place of Birth | ☐ M ☐ F Sex | ☐ Yes ☐ No Are you a veteran?

If you will be residing at an address other than the one above (for example, a summer or retirement address) within the next 12 months, please list your alternate address below.

Alternate Street Address | Phone #

City | State | Zip | From To Dates in Residence at Your Alt. Address

I understand that I have the right to apply for Accidental Disability and/or Ordinary Disability Retirement benefits. If I believe my disability may be the result of a job-related incident or injury, I may apply for Accidental Disability benefits and must answer all of the questions on this application. I will be required to provide evidence that my disability occurred as a result of a personal injury sustained or a hazard undergone while in the performance of my duties at a definite place and time without serious and willful misconduct on my part.

If I apply for Accidental Disability and PERAC approves my application after considering the Retirement Board's findings, the Regional Medical Panel Report and other evidence, I will be granted an Accidental Disability.

If I apply for an Accidental Disability and PERAC approves an Ordinary Disability application for me based on the Retirement Board's findings, the Regional Medical Panel Report and other evidence, then I may be retired for Ordinary Disability based on this application, if that is my preference and I meet the other requirements for Ordinary Disability benefits.

I apply to be retired on the basis of (Please check one):

☐ Accidental Disability ☐ Ordinary Disability ☐ Either Accidental or Ordinary Disability

I sign this application under the pains and penalties of perjury. I affirm that the information presented in this application is correct, complete and accurately presented. I understand that giving false or incomplete information on this application may subject me to loss of my benefits as well as civil and criminal penalties.

Applicant's Signature _____ Date _____

Applicant's Last Name	First	M.I.	xxx-xx- Social Security #

Statement of Applicant's Duties

In order to receive a disability retirement allowance, a member must be permanently and totally disabled from performing the essential duties of his/her position. Essential duties are those duties or functions of a job or position that must necessarily be performed by an employee to accomplish the principal object(s) of the job or position. In accordance with PERAC's regulations, 840 CMR 10.07, your employer is required to identify the essential duties of your position.

(1) Please state the medical reason for which you are filing this application for disability retirement.

(2) Please describe the duties that you are required to perform in your current position.

(3) How frequently are you required to perform these duties?

(4) Please describe the duties that you are unable to perform as a result of your disability.

(5) When did you cease to be able to perform all of the essential duties of your position?

Applicant's Last Name | First | M.I. | Social Security # (xxx-xx-)

Your Employment History

Your Current Position (From which you plan to retire)

Title | Name of Department

Employer's Street Address | Name of Head of Department

City | State | Zip | Name of Direct Supervisor

Phone # | Fax # | From To Dates Employed

All of Your Previous Positions

Please list all previous employment in chronological order, beginning with your first position. Include all prior public and private employment. Please note that, if any other Massachusetts agency or unit has ever employed you, you may be eligible to purchase creditable service for that public sector employment. Contact your retirement board for further information about making such a purchase. If you need additional space, please attach a separate sheet.

Employer's Name | From To Dates Employed

Street Address | City | State | Zip

Employer's Name | From To Dates Employed

Street Address | City | State | Zip

Employer's Name | From To Dates Employed

Street Address | City | State | Zip

Applicant's Last Name	First	M.I.	Social Security #
			xxx-xx-

Statements About Your Background, Qualifications & Recent Physical Activities

(1) Are you a high school graduate? ☐ Yes ☐ No
If you completed some but not all of high school, please indicate the last grade that you did complete._____

(2) Are you a college graduate? ☐ Yes ☐ No
If you completed some but not all of college, please indicate the last year that you did complete._____

(3) Special qualifications, certifications or licenses that you hold:

(4) For the period of the last year, please describe your physical activities, including:
(A) Medical rehabilitation activities

(B) Activities of daily living (for example, driving, cleaning, etc.)

(C) Sports or other strenuous activities

(D) Other employment since the onset of your disability

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G.L. c. 32, § 15

Have you been officially investigated for or charged with misappropriation of funds from your employer or convicted of any crime related to your office or position? ☐ Yes ☐ No
If **yes**, please provide documentation.

If you are applying for ordinary disability, you are not required to complete the rest of page 5 & 6-8. But, if you feel that responses in this section are relevant, you may offer them.

Reason for Accidental Disability

One of the conditions for receiving approval of an application for accidental disability retirement is that your retirement board must find that your disability is the natural and proximate result of either a personal injury you sustained (usually, one or several specific incidents), or a hazard undergone (generally, exposure to a harmful situation over a period of time).

Please identify the reason for your disability: ☐ Personal Injury ☐ Hazard

In describing the personal injury that you sustained or the hazard to which you were exposed, it is important to be as specific as possible.

(1) Date(s)

(2) Specific time(s) or if hazard, length of time exposed

(3) Location(s)

(4) Description of incident(s) or hazard

Applicant's Last Name	First	M.I.	Social Security #
			xxx-xx-

(5) Please describe the job duties you were performing just prior to and at the time you sustained your personal injury or were exposed to the hazard.

Incident Reports

Please provide the following information about each person or agency with which you filed a report of the incident(s) that you sustained or the hazard to which you were exposed.

Name (Last, First, Middle Initial) | Agency

Street Address | City | State | Zip

Phone # | Date You Filed Report

Name (Last, First, Middle Initial) | Agency

Street Address | City | State | Zip

Phone # | Date You Filed Report

Witness Data

For each witness to the incident(s) or hazard(s) that you've described, please provide the following information.

Name (Last, First, Middle Initial) | Phone # | Relationship To You

Street Address | City | State | Zip

Name (Last, First, Middle Initial) | Phone # | Relationship To You

Street Address | City | State | Zip

Applicant's Last Name	First	M.I.	Social Security #
			xxx-xx-

Other Actions Taken

As a result of the incidents or hazards that you have described, have you filed a grievance pursuant to a collective bargaining agreement?

☐ Not applicable ☐ No ☐ Yes

If "**yes**", please describe the status of your grievance.

Did your employer take any administrative or disciplinary action as a result of the incidents or hazards you have described?

Workers' Compensation

Have you applied for, or are you receiving, or have you received weekly Workers' Compensation benefits or a Workers' Compensation settlement related to your claimed disability?

Section 111F Benefits

Have you received or are you receiving benefits, related to your claimed disability, pursuant to G.L. c. 41, § 111F?

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Emergency Medical Treatment

If you received emergency medical treatment as a result of the incident(s) or hazard(s) you've described, please provide the following information about each health care provider who furnished such treatment to you.

Health Care Provider's Name | Hospital/Facility

Street Address | City | State | Zip

Phone # | Date(s) of Treatment From To

Health Care Provider's Name | Hospital/Facility

Street Address | City | State | Zip

Phone # | Date(s) of Treatment From To

Health Care Provider's Name | Hospital/Facility

Street Address | City | State | Zip

Phone # | Date(s) of Treatment From To

Applicant's Last Name	First	M.I.	Social Security #
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Hospitals and Medical Facilities

Please list **all** hospitals and medical facilities with which you have consulted or at which you have received any treatment for any condition within the last five years. Begin with the hospital or medical facility from which you first sought a consultation or treatment. If you need more space, you may attach additional sheets.

Name of Facility	Reason for Visit

Street Address	City	State	Zip

Phone #	Date(s) of Treatment
	From To

Name of Facility	Reason for Visit

Street Address	City	State	Zip

Phone #	Date(s) of Treatment
	From To

Name of Facility	Reason for Visit

Street Address	City	State	Zip

Phone #	Date(s) of Treatment
	From To

Applicant's Last Name	First	M.I.	Social Security #
			xxx-xx-

Physicians

Please list all physicians with whom you have consulted or from whom you have received any treatment for any condition within the last five years. Begin with the physician you consulted first. If you need more space, you may attach additional sheets.

Name of Physician | Reason for Visit

Street Address | City | State | Zip

Phone # | From To Date(s) of Treatment

Name of Physician | Reason for Visit

Street Address | City | State | Zip

Phone # | From To Date(s) of Treatment

Name of Physician | Reason for Visit

Street Address | City | State | Zip

Phone # | From To Date(s) of Treatment

Applicant's Last Name	First	M.I.	Social Security #
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Primary Treating Physician

Your retirement board will request a statement certifying your disability status from the physician who is treating you for your disability. Please provide the following information about the physician who has provided you with primary treatment in connection with your disability.

Name of Primary Treating Physician	Phone #

Street Address	City	State	Zip

Other Conditions

Please describe any other circumstances, events or physical conditions that contributed or may have contributed to your disability.

Attorney Information

If you are represented by an attorney in this disability retirement application process, please provide the following information so that we may contact him or her as necessary.

Name of Attorney

Name of Firm	Phone #

Street Address	City	State	Zip

Applicant's Last Name	First	M.I.	Social Security #
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Insurance Coverage

If you have any insurance that covers the incidents or hazards that you have described, please provide the following information about each policy.

Name of Insurance Company	Policy # (*If Known*)

Street Address	City	State	Zip

Phone #	Type of Coverage

Name of Insurance Company	Policy # (*If Known*)

Street Address	City	State	Zip

Phone #	Type of Coverage

Retirement Board Authorization to Use or Disclose Protected Health Information

1. I hereby authorize: _____
(physician, hospital, insurance company, employer, other health/rehabilitation entity)
to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to Federal or State law protecting its confidentiality. Information released on this authorization, if redisclosed by the recipient, is no longer protected.

2. Patient Name: _____ Date of Birth: _____

_____ _____ _____ _____
Street Address City State Zip

3. Information to be disclosed to: _____ Retirement Board
Enter Address:

_____ _____ _____ _____
Street Address City State Zip

4. Please check the box below to authorize release of your complete medical record, or, use the lines below to stipulate any exceptions.

☐ Authorize Release of Complete Medical Record
Exceptions:

_____

5. I have checked the box below indicating the purpose for the disclosure of this information.

☐ Disability Retirement Application: (G.L. c.32, §6 & §7)

☐ Restoration to Service Evaluation (including rehabilitation): (G.L. c.32, §8)

☐ Accidental Death Benefit: (G.L. c.32, §9 & §100)

6. I understand I may revoke this authorization at any time by notifying the Retirement Board in writing, unless action has already been taken in reliance upon it, or during an appeal under the applicable law.

7. This authorization will expire upon final determination of my disability application or Comprehensive Medical Evaluation/Rehabilitation/Restoration to Service process or up to one year from date signed below.

8. _____
Signature of Patient or Legal Representative

10. _____
Date

9. _____
Printed Name of Patient or Patient's Representative

_____
Relationship to Patient/Authority to Act for Patient if Applicable

Retirement Board Authorization to Use or Disclose Protected Health Information (Continued)

All numbered entries must be completed for this authorization to be valid.

Please note, Retirement Boards are not covered entities under the Health Insurance Portability and Accountability Act (HIPAA), however all information is treated in a confidential manner consistent with Federal and State privacy laws.

How This Information is To Be Used

Pursuant to Massachusetts General Laws, Chapter 32, sections 6 and 7, the Public Employee Retirement Administration Commission (PERAC) is responsible for appointing regional medical panels to evaluate members seeking Disability Retirement. During the application process the Retirement Board and PERAC may obtain, share, and disclose information as necessary to complete the Disability Retirement process.

Pursuant to Massachusetts General Laws, Chapter 32, section 8, PERAC is also responsible for conducting Comprehensive Medical Evaluations (CME), offering Rehabilitation, and scheduling Restoration to Service (RTS) examinations, to determine if the member is able to perform the essential duties of his/her former position, with or without rehabilitation. During this process, the Retirement Board and PERAC may obtain, share, and disclose information as necessary to complete this evaluation process.

The information used/shared/disclosed during the four phases of the Disability process may include information provided by physicians, hospitals, insurance companies, employer, and other health/rehabilitation entities.

Please note, this original authorization form may be copied and reissued for the purpose of gathering and sharing protected information necessary to the Disability Application, CME, Rehabilitation, and RTS examinations.

Applicant's Last Name	First	M.I.	Social Security #
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Applicant's Authorization for Release of Tax Records

This will certify that I authorize release of information from the federal Internal Revenue Service and the Massachusetts Department of Revenue relative to my annual gross earned income pursuant to any agreement between the federal Internal Revenue Service, the Massachusetts Department of Revenue and the Public Employee Retirement Administration Commission.

I understand that G.L. c. 32, § 6 and 7 require this authorization and my failure to provide this release may result in the denial, suspension and/or termination of my benefits.

_____

Signature of Applicant

Name of Applicant (Please Print)

xxx-xx-

Social Security #

Applicant's Last Name	First	M.I.	Social Security #
			xxx-xx-

Regional Medical Panel Selection Form

Unless your retirement board denies your application as a result of an initial fact-finding hearing, you must have a regional medical panel examination. The Public Employee Retirement Administration Commission (PERAC) appoints all regional medical panels.

When your retirement board determines that your application for disability retirement is complete, the board (which meets at least once each month) may petition PERAC to appoint a three member, state-financed, independent regional medical panel to examine you.

- No physician who has already examined you or treated you, except as part of a prior regional medical panel, can be appointed to a panel to examine you.

- PERAC will schedule the regional medical panel examination(s) and notify you at least 14 days in advance of the date(s), time(s), and location(s).

Three Separate Single Examinations or One Joint Examination

- You have the right to request three separate single physician examinations when you file your disability application. Such separate examinations can be scheduled by PERAC to take place on three separate days in three separate locations.

- If you do not request separate single examinations at application filing time, PERAC will generally schedule a joint examination. In instances where a joint examination cannot be convened in a timely fashion, PERAC may schedule separate single examinations instead.

- You may request separate examinations at any time prior to a joint examination date, but PERAC will not ordinarily consider requests for separate examinations less than 48 hours prior to a scheduled joint examination.

You must indicate whether you prefer one joint examination or three separate single examinations by checking one of the boxes below:

☐ I want to be examined by a joint regional medical panel.

☐ I want to be scheduled for three separate single examinations.

By signing, I acknowledge that if I fail to appear at the scheduled medical appointment(s), I will be required to reimburse the Commonwealth for the cost of the examination, prior to the scheduling of a new examination.

Signature of Applicant _____ Date _____

Applicant's Last Name	First	M.I.	xxx-xx- Social Security #

The following authorization and selection forms are included in your application. Make sure that you complete each of these forms and return them to your retirement board along with the rest of your completed application:

- Your signed *Authorization for Release of Medical and Insurance Records*
- Your signed *Authorization for Release of Tax Records*
- Your signed *Regional Medical Panel Selection Form*

Copies of the following documents should be attached to your Application:

- Your birth certificate
- Your military form DD214, if applicable to your personal situation
- Copies of incident reports that you filed, if applicable to your personal situation

If your application is approved, you may need to submit additional documents, including, if applicable:

- Your marriage certificate
- Your spouse's birth certificate
- Your dependent children's birth certificates

Addendum Sheet
to the
Member's Application for Disability Retirement

Please use this sheet to provide further information in the event that you find the space provided on the form to be insufficient. Please identify the question(s), by Page Number and Question Number, for which you are providing further information.