

## DISABILITY APPLICATION CHECKLIST

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PLEASE INCLUDE THE FOLLOWING WITH YOUR RETIREMENT APPLICATION. APPLICATIONS RECEIVED WITHOUT THE PROPER PAPERWORK WILL DELAY PROCESSING.

Disability Application

Salary Evaluation Form

Direct Deposit Form

Copy of Member's Birth Certificate and Social Security Card

Copy of Beneficiary's Birth Certificate and Social Security Card (Required if Option other than Maximum Chosen)

Copy of Certificate of Elected Service (Required for Elected Officials Only)

Spousal Consent Form (Required if Legally Married)

Have final earnings and contributions been reported? Yes No (circle one)

Certified Copy of Death Certificate (Required if widowed)

Copy of Divorce Judgment (Required if divorced)

Disability Report by Immediate Supervisor

Notification of Income from Other Sources

Member Statement of Disabling Condition

Copies of All Medical Records Pertaining to Disability

Authorization to Release Information

MUNICIPAL EMPLOYEES' RETIREMENT SYSTEM of LOUISIANA (MERS)

7937 Office Park Boulevard, Baton Rouge, Louisiana 70809

Phone: (800) 820-1137 or (225) 925-4810 – Fax: (225) 925-4816

APPLICATION FOR DISABILITY

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Attach copy of card

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_ Employer: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Marital Status – Circle One  
Area Code + Number Never Married Legally Married Divorced Widowed

In accordance with the provisions of MERS, application is hereby made for Disability Retirement.

A. Selection is hereby made of the retirement benefit payment plan checked below:

(a) Maximum Allowance Plan

(b) Option Plan Number \_\_\_\_\_ (Choice must be written in blank - Option No. 2, 3, 4.2, or 4.3)

***(Please see page 2 for explanation of benefit options)***

B. Are you now receiving Workers' Compensation or other disability benefits for this disabling condition?

Yes No

**If yes, you must complete "Notification of Income from Other Sources" and submit it with this application.**

C. Have you ever received Workers' Compensation or other disability benefits for this disabling condition?

Yes No

If yes, give the dates you received Workers' Compensation: \_\_\_\_\_

D. Do you receive income from any sources other than the job for which this disability claim is made, Social

Security Administration, Veteran's Administration, or outside employment? Yes No

I hereby designate my beneficiary to receive eligible survivor benefits should I predecease him/her.

Name of beneficiary: \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

\_\_\_\_\_ Social Security # \_\_\_\_\_

Attach copy of card

\_\_\_\_\_  
Witness (cannot be named beneficiary)

I, the undersigned, certify that I have had the above option chosen explained to me to my satisfaction.

\_\_\_\_\_  
Witness (cannot be named beneficiary)

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

\_\_\_\_\_  
Date



## Disability Report by Supervisor

Please type or print in ink all entries except signatures.

This form must be completed by the employee's immediate supervisor. A copy of the employee's official job description must accompany this report when submitted to Municipal Employees' Retirement System (MERS). All responses to information requested should be complete and made to the best of your knowledge and ability. If additional space is required, you may use the reverse side or attach additional sheets. This form must be submitted along with "Application for Disability Retirement".

### Section 1 - Member Information

Name: Last, First, MI, Suffix (Jr., III, etc.)

Title of Position	Social Security Number
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### Section 2 - Supervisor's Statements

1. Do you have any specific knowledge of the cause of the disabling condition? Yes  No  If yes, please describe.

2. In your opinion, when did the disabling condition begin to affect the applicant's performance or job duties?

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (month/day/year)

3. Specifically list the duties stated in the attached official job description that the applicant can no longer perform because of the disabling condition.

4. Specifically list the duties under your supervision that the applicant can still perform.

5. Did this applicant have any physical or mental handicap upon employment? Yes  No  If yes, briefly describe each.

### Section 3 - Leave and Workers' Compensation

7. How many days of sick leave has this applicant taken since the onset of this disabling condition? \_\_\_\_\_

8. Was this an increase in the use of sick leave? Yes  No  If yes, please explain.

9. Was this applicant advanced any extended sick leave days? Yes  No

10. Is this applicant currently receiving or has he or she ever received Worker's Compensation or any other disability benefits because of the disabling condition? Yes  No  If yes, please provide information below:

Name of Worker's Compensation Provider		Telephone Number
Address (Street/P. O. Box)	City, State, and Zip Code	

### Section 4 - Supervisor's Certification

I certify that the information contained in this form is true to the best of my knowledge.

Municipality Name	Supervisor's Name (Print in ink or type)	
Supervisor's Signature (Do not print or type)	Title	Date Signed (MM/DD/YYYY)

## Notification of Income from Other Sources

Please type or print in ink all entries except signatures.

This form must be completed and submitted along with an Application for Disability Retirement if the applicant answered "yes" to questions in Section 1 of the application regarding workers' compensation and other sources of income.

Member Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### Section 1 - Worker's Compensation

Note: Please have the Workers' Compensation insurance carrier provide MERS with a written statement verifying the information provided below:

Name of insurance carrier:		Address of insurance carrier:	
Phone number of insurance carrier:	Amount of monthly benefit:	Date first eligible to receive Workers' Compensation benefits:	

### Section 2: Income from other employment

**Are you self-employed?** Yes  No  **If yes:** Attach a separate sheet giving the name of the business, the type of business, an explanation of the type of work performed and the amount of annual income received from self-employment. MERS may contact you to request documents for verification of income reported.

**Do you receive income from any source for which you receive a W-2 or 1099?** Yes No  
**If yes, please explain:**

**Do you have a job other than the job for which this disability claim is made?** Yes No  
**If yes,** complete the information below and attach a copy of two (2) recent pay stubs.  
**Do you plan to continue this employment?** Yes No

Employer's name:		Employer's address:	
Employer's phone number:	Monthly Salary:	Job Title:	

### Section 3 - Member and witnesses' signatures

I hereby certify that the information provided herein is true and correct. I agree to provide additional documents as may be required by MERS to verify the accuracy of this information. I understand that income I receive from sources not defined as "allowable income" by MERS could decrease the amount of my disability retirement benefit.

Signature of Member:	Date:
Print Name:	

Signature of Witness:	
Print Name of Witness	Date:

Address of Witness:	
Signature of Witness:	

Print Name of Witness	Date:
Address of Witness:	

## Member Statement of Disabling Condition

Please type or print in ink all entries except signatures

Describe, in detail, the nature of your disabling condition and how the condition affects current job performance. If additional space is needed, you may attach additional sheets. This statement must be submitted to the Municipal Employees' Retirement System (MERS) with the *Application for Disability Retirement*. Both pages of this form must be completed.

Section 1 - Member Information				
Last Name	First Name	Middle Initial	Suffix (Jr., III, etc.)	Social Security Number
Address (Street/P. O. Box)			Primary Telephone Number	
City, State, and Zip Code			Secondary Telephone Number	
Title of Position				
Section 2 - Member Description of Condition				
1. When did your disability begin? _____/_____/_____				(Enter as MM/DD/YYYY)
2. Were you treated for this condition prior to your employment with your current employer?				Yes                      No
If yes, date first treated: _____/_____/_____				(Enter as MM/DD/YYYY)
<b>Information on treating physician:</b>				
Name of Physician			Primary Telephone Number	
Address (Street/P. O. Box)			Area of Specialty	
City, State, and Zip Code				
3. Describe the nature of your disabling condition:				
4. Describe your job duties and how your disabling condition affects your ability to perform your job:				

## Member Statement of Disabling Condition - Continued

Member Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

### Section 2 - Member Description of Condition - Continued

5. Reports regarding my disability condition will be submitted by the following physicians who have examined me prior to submitting my Retirement Application to MERS (you may attach additional sheets if needed). One physician must be a specialist in the same area you are claiming disability. Copies of all available medical records, especially typed reports from lab tests, x-rays, MRIs, CT scans, etc., must also be submitted. DO NOT send the actual x-ray

Name of Physician	Primary Telephone Number
Address (Street/P. O. Box)	Area of Specialty
City, State, and Zip Code	
Name of Physician	Primary Telephone Number
Address (Street/P. O. Box)	Area of Specialty
City, State, and Zip Code	
Name of Physician	Primary Telephone Number
Address (Street/P. O. Box)	Area of Specialty
City, State, and Zip Code	
Name of Physician	Primary Telephone Number
Address (Street/P. O. Box)	Area of Specialty
City, State, and Zip Code	
Name of Physician	Primary Telephone Number
Address (Street/P. O. Box)	Area of Specialty
City, State, and Zip Code	

6. Mark the major area of specialty of the physician you consult for your disability. This will determine which LA State Medical Board physician will review your medical records. **Mark only one box.**

- Internal Medicine (Gastroenterology, Nephrology, Pulmonary, Urology)
- Neurology
- Orthopedics (Rheumatology)
- Cardiology
- Oncology
- Psychiatry
- Other (Specify):

\_\_\_\_\_

I understand that my application will not be submitted to the LA State Medical Board until all required information, including copies of all medical records pertaining to my disabling condition, is received from all physicians listed on this form.

Signature of Member (Do not print or type) 	Date Signed (MM/DD/YYYY)
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# Municipal Employees' Retirement System (MERS)

## Authorization to Request Information

I, \_\_\_\_\_, social security number (last 4 digits only) \_\_\_\_\_ understand that if approved for Disability retirement benefits, by way of this release, I give my permission and authorization to the Municipal Employees' Retirement System (MERS) to request information related to documentations or forms regarding earned income and/or benefit(s) I may be receiving now or in the future from the following sources: Internal Revenue Service, Department of Labor and/or the Social Security Administration.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date





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## AUTHORIZATION TO RELEASE INFORMATION

I authorize any employer, insurance company, Medical Insurance Bureau, Workers' Compensation Board, Social Security Administration, physician, practitioner, hospital, or health care institution to release to the Municipal Employees Retirement System (MERS) any medical information, which may be required to establish the validity of this claim. I also authorize such company, person or organization to disclose any relevant claim information required for the review of this claim. I agree that a photocopy shall be as valid as the original.

I have read and understand all pages of this application and certify that, to the best of my knowledge, all information provided on this document is true and correct.

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Signature

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Date