



Mail completed form to:  
30-30 47th Avenue, 10th Fl  
Long Island City, NY 11101

## INSTRUCTIONS FOR MEMBERS FILING FOR DISABILITY RETIREMENT

Please follow these instructions carefully. They are designed to ensure that your application will be processed promptly.

- **Please check the application packet to see that all of the following forms are included:**
  - Application for Accident Disability Retirement or Application for Ordinary Disability Retirement
  - Applicant's Personal Report of Disability
  - Physician's Report of Disability
  - General Authorization For Medical Information
  - Disability Questionnaire
- Make sure that the application is acknowledged before a Notary Public or Commissioner of Deeds before it is mailed to NYCERS. If you are submitting the application in person you will not have to have it notarized if you can show a job identification card (picture).
- Have the Physician's Report of Disability filled out by the physician who has been treating you for the disabling condition. We have included three copies of this form, in case you have been treated by more than one physician. Please note that you must complete the authorization at the bottom of the form.
- The Applicant's Personal Report of Disability must contain the names of all hospitals, medical groups and physicians that have treated you for the disabling condition.
- A separate General Authorization for Medical Information must be completed for each hospital and medical group listed on the Applicant's Personal Report of Disability form as having treated you for your disabling condition. Hospitalization information should include the dates of admission and discharge and your hospital number.
- If you have any questions concerning these instructions, please call the Medical Division.

**Please read carefully: It is your responsibility to:**

1. Submit all current medical evidence to support the claim for disability retirement at least 10 days prior to the date you will be given an appointment to appear before the Medical Board. We will request medical evidence on your behalf from a hospital or H.I.P. center (not personal physicians). We cannot schedule you to come before the Medical Board until we have the required medical evidence. If the evidence is not received timely, your application could be officially suspended or closed, and you may not be eligible to reapply for disability retirement depending on your employment status.
2. Submit all X-Rays, CT Scans, MRI Films, and reports by the appointment date.
3. (For Tier 3 and Tier 4 members with Tier 3 rights only) Submit proof of filing for a Primary Social Security Disability Award within 60 days of applying for disability retirement with NYCERS. See the application for details.
4. Provide (if you are approved for Accident Disability Retirement or a Line-of-Duty Disability Retirement, except Uniformed Sanitation members) a recent Workers' Compensation Notice of Decision when you submit your option selection forms. If you are not receiving Workers' Compensation benefits, you must submit a statement from the Workers' Compensation Board regarding the status of your case. We cannot finalize payment of your disability benefits until we have this information.
5. Notify this office immediately if you plan to have surgery for the illness/injury for which you are applying for disability retirement. We will schedule you to appear before the Medical Board (if you submit the required medical evidence) prior to the surgery since the Medical Board will not be able to examine you for this illness/injury until six months after the surgery. **If you do not appear for this examination, you must submit proof that you were medically unable to do so. Failure to provide this proof will result in the suspension or closure of the application and depending on your employment status, you may not be eligible to re-apply for disability retirement. Please bear in mind that you will have to be examined by the NYCERS Medical Board before a determination can be made on your application for disability retirement.**

**Please note: Should you apply for and receive a return of your accumulated salary deductions your membership will terminate and your application will not be processed.**



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**Application for Disability Retirement  
Tier 1 Members**

Please read the information on the Terms page before completing this application.

**NOTE: If the address you provide on this form is different from your address in our system, the new address will become your official address in our records.**

I am applying for (Check one box only):  Accident Disability  Ordinary Disability  Both Accident and Ordinary  World Trade Center Disability

Member Number	Last 4 Digits of SSN	Date of Birth [MM/DD/YYYY]
		/ /

Agency	Title

**PART A.** To be completed by Accident Disability Applicants only (if applying for Ordinary Disability only, proceed to Part B): I am physically incapacitated for the performance of City service as a natural and proximate result of an accidental injury received in such City service, while a member and while in the performance of duty and not as the result of willful negligence on my part. The accident that caused my disability occurred as follows: (PLEASE PRINT)

Date [MM/DD/YYYY]	Time
/ /	

Place

Conditions and Description

Result of Accident

Witnesses

**PART B:** To be completed by ALL applicants for disability retirement: In accordance with provisions of law governing the New York City Employees' Retirement System, I hereby make application for retirement from City service on account of physical or mental disability which incapacitates me for service. The nature of this disability is described in the Applicant's Report of Personal Disability. I am also submitting herewith a completed Physician's Report of Disability and an authorization for release of my hospital records directly to NYCERS' Medical Board.

When you calculate my disability retirement benefit, please use the following person

Name

Relationship [MM/DD/YYYY]

who is my  and whose date of birth is 

/ /

to estimate my joint and survivor options. (Note: This form is not a designation of beneficiary.)

**Sign this form and have it notarized, Page 2**



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Member Number	Last 4 Digits of SSN

**PART C: Mandatory for Ordinary Disability Applicants - Optional for Accident Disability Applicants:**

**Federal Tax Withholding**  
 Federal tax law provides that all payers are required to withhold Federal income tax on periodic payments (similar to wages), unless you elect to be excluded from such withholding. This election will remain in effect until revoked by you. If you do not complete this election, Federal income tax will be withheld at the rate of a married individual claiming three exemptions.

**Please indicate your withholding selection by marking the appropriate choice below:**

1.  Do not withhold Federal income tax from my pension. (Do not complete 2 or 3 if you select this option)

2.  Withhold based on  number of exemptions using the following status (You **may** also enter a dollar amount in choice 3):

(Check one only)     Single                       Married                       Married, but withhold at higher "Single" rate

3.  In addition to the amount withheld based on my exemptions and filing status in choice 2,  
 I would like to withhold \$  Per Month (Must specify dollar amount only)

**Note:** You cannot enter an amount here without entering a number of exemptions in choice 2 (even if that number is zero).

Signature of Member	Date

First Name	M.I.	Last Name	Home Phone #
			(    )

Address	Apt. Number

City	State	Zip Code

**This form must be acknowledged before a Notary Public or Commissioner of Deeds**

State of \_\_\_\_\_ County of \_\_\_\_\_ On this \_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_, personally appeared before me the above named, \_\_\_\_\_, to me known, and known to me to be the individual described in and who executed the foregoing instrument, and he or she acknowledged to me that he or she executed the same, and that the statements contained therein are true.

If you have an official seal, affix it

Signature of Notary Public or Commissioner of Deeds \_\_\_\_\_

Official Title \_\_\_\_\_

Expiration Date of Commission \_\_\_\_\_

If you are submitting the application in person you will not have to have it notarized if you can show a job identification card (picture).

**Sign this form and have it notarized, THIS PAGE**



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**PLEASE NOTE**

A Tier 1 member of the New York City Employees' Retirement System (NYCERS), who is in City service, may apply for retirement:

**Under the Ordinary Disability Retirement provisions of the Administrative Code of the City of New York:**

- on account of disability received from any cause, provided that the member has ten or more years of City service, and was otherwise in City service in each of the ten years preceding retirement, except for Correction Officers for whom there is no service requirement. Members of the Uniformed Sanitation Force plans are required to have five or more years of Allowable Sanitation Service, or ten or more years of City service and having been a member otherwise in City service in each of the five years next preceding the date of retirement;

**Under the Accident Disability Retirement provisions of the Administrative Code of the City of New York:**

- if physically or mentally incapacitated for the performance of City service as a natural and proximate result of an accidental injury received in such City service, while a member and not as a result of willful negligence on the part of the member. Such application must be filed with NYCERS within two years from the happening of such accident. (Except for members of the uniformed force of the departments of Sanitation and Correction.)

To apply for a disability retirement, you should complete this application together with Applicant's Report of Personal Disability, have the application acknowledged before a Notary Public or Commissioner of Deeds, and file both forms in the office of the New York City Employees' Retirement System. Mail the forms to NYCERS at 30-30 47th Avenue, 10th Floor, Long Island City, NY 11101, or bring them in person to 340 Jay Street, Mezzanine Level, in downtown Brooklyn. A Physician's Report of Disability should also be filed with NYCERS.

You will be advised as to the date set for an examination by, or under the direction of, NYCERS' Medical Board.

If the Medical Board finds you disabled, and recommends retirement, the report on the application will be presented to the Board of Trustees. Thereafter, a letter will be sent setting forth the amounts payable under the various options available to you. You will then be required to select an option. If you fail to select an option in the period prescribed, you will be awarded the Maximum retirement allowance without optional modification.

If the Medical Board recommends denial of your application, and the Board of Trustees accepts the recommendation of the Medical Board, notice of the denial will be sent to you.

**World Trade Center (WTC) Disability Law**

The World Trade Center (WTC) Disability Law provides a presumption of accidental disability for NYCERS members who participated in WTC Rescue, Recovery or Clean-Up Operations and become disabled from a Qualifying Condition or Impairment of Health. Benefits are paid according to the provisions that cover accidental disability for your tier and title. For complete details and eligibility requirements, please read our WTC Disability Law Fact Sheet #703, available on our website at [www.nycers.org](http://www.nycers.org).

**Withdrawal of Application**

Provided that the NYCERS Medical Board has not yet finalized its finding, you may withdraw your application for disability retirement upon written request to the Retirement System and with approval of the Medical Board.

**Sign this form and have it notarized, Page 2**



**Applicant's Report of Personal Disability**

Please return with member's application for disability retirement.

Membership Number	Last 4 Digits of SSN	Date of Birth [MM/DD/YYYY]
		/ /

First Name	M.I.	Last Name

Address	Apt. Number

City	State	Zip Code

**To NYCERS' Medical Board:**

I, the undersigned, believe that I am incapacitated for further service as a

Title

in the Department of

because \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I am being treated for this condition by the following doctor(s):

**Name of Doctor(s) and Addresses** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Note:** The Physician's Report of Disability must be completed by each doctor listed above and submitted with your application

I have been hospitalized and/or treated for this condition at the following hospital(s) and/or medical group(s):

Name of Hospital(s) and/or Medical Group(s) and Addresses	Treatment Dates [MM/DD/YYYY]
	/ /
	/ /
	/ /

**Note:** An appropriate authorization for release of medical information must be completed for each hospital and/or medical group listed above, and submitted with your application

I will appear before NYCERS' Medical Board at 340 Jay Street, Mezzanine Level, in downtown Brooklyn when necessary for me to be examined.

**Note: If you are unable to appear before NYCERS' Medical Board for examination, please forward your physician's certificate stating why.**

Signature of Member	Date



**Physician's Report of Disability**

**To be returned to NYCERS with member's application for disability retirement**

**To NYCERS' Medical Board:**

This is to certify that

First Name	M.I.	Last Name

an employee in the New York City Department of

is under my care for the following:

**Diagnosis:** (Clinical problem and duration)

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If caused by an accident: (Type, Place and Date)

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Date [MM/DD/YYYY]  

/ /

---

When, if ever, may he or she return to the full duties of his or her title?

Date [MM/DD/YYYY]

/ /

**Objective evidence:**

X-Rays, EKG (Photocopies), Laboratory Reports, Pertinent physical findings, Consultant Reports, Hospital Reports, Etc.

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**Subjective evidence:**

Symptoms, Complaints, Etc.

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**Treatment and result:**

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Member Number	Last 4 Digits of SSN

Physician First Name	Physician Last Name	Title (MD, DO, DC etc.)

Address	Apt. Number

City	State	Zip Code

Signature of Physician	Date

**Applicant's Authorization for Release of Information**

Dear Doctor \_\_\_\_\_, you are hereby authorized by me to fill out this form for the information of the Medical Board of the New York City Employees' Retirement System.

Signature of Applicant	Date

First Name	M.I.	Last Name

in Care of (if applicable)	Full Social Security Number

Address	Apt. Number

City	State	Zip Code



### General Authorization for Medical Information

This form authorizes NYCERS to obtain medical information pertaining to those filing for disability. NYCERS understands that information about your health is personal and we are committed to protecting your privacy. Please be sure you understand how NYCERS will use your medical information prior to signing this form. Should you have any questions, please contact our Call Center at 347-643-3000.

Member Number	Last 4 Digits of SSN	Date of Birth [MM/DD/YYYY]
		/ /

First Name	M.I.	Last Name

Address	Apt. Number

City	State	Zip Code

Name of Hospital or Medical Group

Dates of treatment/service:

[MM/DD/YYYY] / /	[MM/DD/YYYY] / /	[MM/DD/YYYY] / /	[MM/DD/YYYY] / /
---------------------	---------------------	---------------------	---------------------

Expiration date of this authorization:

[MM/DD/YYYY] / /
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**Please initial each of the following to state your understanding of this form.**

- I understand that by completing this form in full, I authorize the use and disclosure of my medical records for the purpose of applying for disability retirement.
- I understand that this information may be re-disclosed if the recipient(s) described on this form is not required by applicable law to protect the privacy of the information and such information is no longer protected by federal health information privacy regulations.
- I understand that my medical records may contain information relating to Alcohol or Drug Abuse, genetic testing, psychiatric care and/or confidential HIV/AIDS related information.
- I understand that if I am authorizing the use or disclosure of HIV/AIDS related information, the recipient is prohibited from using or disclosing any HIV/AIDS related information without my authorization unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS related information, I may contact New York State Division of Human Rights at 212-480-2493 or the New York City Commission of Human Rights at 212-306-7450. These agencies are responsible for protecting my rights.
- I have read this form and all of my questions about this form have been answered. By signing below I acknowledge that I have read and accept all of the above and hereby authorize any hospital, medical group, or other organization to disclose all information to the New York City Employees' Retirement System.

<b>Signature of Member</b>	<b>Date</b>







Member Number	Last 4 Digits of SSN

(B) Dates of admission and discharge:

- 1). \_\_\_\_\_
- 2). \_\_\_\_\_

(C) Diagnosis(es):

- 1). \_\_\_\_\_
- 2). \_\_\_\_\_

Was surgery performed?    **Yes**    **No**   If Yes, give dates and type of surgery performed.

1). _____	[MM/DD/YYYY] / /
2). _____	[MM/DD/YYYY] / /

8. Check all relevant boxes that your job requires.

**Lifting**    **Working Outdoors**    **Walking**    **Climbing**    **Other** \_\_\_\_\_

9. Do you feel that you are totally and permanently disabled from performing the usual duties of your title?

**Yes**    **No**

Could you do other work?    **Yes**    **No**

10. Are you working now?    **Yes**    **No**

If Not, when did you stop?   [MM/DD/YYYY]  
/ /

11. What is the name of your union, and local? \_\_\_\_\_

12. Are you receiving Social Security Disability Benefits?    **Yes**    **No**

13. Please give a daytime telephone number where you can be reached.   (   )

14. Did you have previous service with New York City or New York State prior to your current membership?

**Yes**    **No**

If yes, When?   [MM/DD/YYYY]  
/ /   [MM/DD/YYYY]  
/ /   [MM/DD/YYYY]  
/ /



Empty rectangular box for member information.

Member Number	Last 4 Digits of SSN
<input type="text"/>	<input type="text"/>

**This section is to be completed ONLY by members applying for disability retirement as a result of an accidental injury during the performance of their duties while in City service.**

15. What is your date of birth?  / / (Attach a copy of your Birth Certificate.)

16. What was the date of the injury?  / /

17. What part of your body was injured?

\_\_\_\_\_

18. What were you doing when you were injured?

\_\_\_\_\_

19. Were you on full duty at the time of the injury?  Yes  No

20. Were you performing any unusual work at that time?  Yes  No  
If Yes, describe.

\_\_\_\_\_

21. What is the nature of the injury?

\_\_\_\_\_

22. How were you injured?

\_\_\_\_\_

23. Were there any witnesses to the incident when you were injured?  Yes  No  
If Yes, give Name, Title and Address (if known).

\_\_\_\_\_

24. When did you stop working because of the injury?  / /

25. Do you have proof of this occurrence?  Yes  No

26. When were you first treated for the injury referred to above, and by whom?

Date  / /

By Whom? \_\_\_\_\_

Place? \_\_\_\_\_

27. State the name of medical persons or institutions who treated you for the injury described. State dates and frequency.

Name of Person or Institution \_\_\_\_\_  / /

Name of Person or Institution \_\_\_\_\_  / /

Name of Person or Institution \_\_\_\_\_  / /



[Empty box for member information]

Member Number

Last 4 Digits of SSN

[Member Number and Last 4 Digits of SSN input fields]

28. Have you had any similar disability before the injury?  Yes  No

29. Have you had any other accidents or injuries on the job (either before or after the injury claimed herein)?

Yes  No

[MM/DD/YYYY] / /  
/ /

If Yes, give dates and description of injury \_\_\_\_\_

\_\_\_\_\_

30. Have you had any accidents or injuries off the job?  Yes  No

[MM/DD/YYYY] / /  
/ /

If Yes, give dates and descriptions of injury \_\_\_\_\_

\_\_\_\_\_

31. Did you return to full duty after the injury herein claimed?  Yes  No

If Yes, When? [ / / ] [MM/DD/YYYY]

32. Did you return to light duty after the injury herein claimed?  Yes  No

If Yes, When? [ / / ] [MM/DD/YYYY]

33. Are you being treated for any other injuries/disorders?  Yes  No

If Yes, describe injury/disorder and treatment.

34. Do you drink alcohol regularly (one-half pint or more per-week)?  Yes  No

Do you drink occasionally?  Yes  No

If yes, how often? \_\_\_\_\_

How much? \_\_\_\_\_

35. Do you take any medications daily?  Yes  No

If Yes, What? \_\_\_\_\_

36. Do you use any recreational drugs?  Yes  No

If Yes, What and how often? \_\_\_\_\_

37. Did you file a Workers' Compensation claim?  Yes  No

Are you receiving Workers' Compensation payments?  Yes  No

38. If Yes, how much bi-weekly? \_\_\_\_\_

Signature of Member

Date

[Signature and Date input fields]



# Disability Retirement

Tier 1 and 2

July 2012

## TIER MEMBERSHIP INFORMATION:

1. Employees who became members of NYCERS prior to July 1, 1973 are members of Tier 1.
2. Employees who became members of NYCERS on or after July 1, 1973 and before July 27, 1976 are members of Tier 2.

## WHAT IS ORDINARY DISABILITY AND ACCIDENTAL DISABILITY?

An ordinary disability is defined as an injury or illness that prevents an employee from performing the routine duties of his or her job title.

An accidental disability can only result from an accident occurring in the performance of duty. The courts have defined the term accident as a "sudden, fortuitous mischance, unexpected, out of the ordinary, and injurious in impact." Not every line of duty injury results in the award of an accident disability retirement benefit.

**The eligibility tables on the back page explain the filing requirements for ordinary and accidental disability.**

## WHAT INFORMATION MUST I SUBMIT TO NYCERS IN ORDER TO BE PROCESSED FOR DISABILITY RETIREMENT?

You must complete and submit the following NYCERS forms:

- Application for Ordinary Disability Retirement or Accidental Disability Retirement (Form #601 for Tier 1 members; Form # 602 for Tier 2 members)
- Your Personal Report of Disability (Form # 605)
- Your Physician's Report of Disability (Form # 606)
- General Authorization for Medical Information (Form # 608)
- Questionnaire to Be Completed by Applicant for Disability Retirement. (Form # 609)

Before you complete any of the above forms, read the instructions in Form # 801 which comes with the application.

If your disability was the result of an accident on the job, your agency must submit an Accident or Incident Report prepared by you and your manager or supervisor, completely describing all the injuries and the events surrounding them. This report is most valuable if it is written at the time of the accident.

Submit your own medical evidence if you are being treated by a private physician. This includes any medical information not otherwise reportable on Form # 606.

Submit all X-rays, CT Scans, MRI films, and reports before your scheduled appointment date with NYCERS' Medical Board.

## HOW DO I APPLY FOR A DISABILITY RETIREMENT?

Here are the steps for your initial application:

- Submit your application (completed and notarized).
- Authorize NYCERS to request information from your hospital or health care facility, AND/OR submit any and all medical evidence from a private physician to support your claim for disability.

NYCERS' will not process your disability retirement application until the Medical Division receives the items above and determines your eligibility. If you are not eligible, you will be notified in writing of the reason.

### Disqualifying Conditions:

You are no longer on payroll, with or without pay, when you appear before the Medical Board.

You did not apply for Accident Disability within two years from the date of the accident (except members of the uniformed forces of the departments of Correction and Sanitation).

You do not have sufficient *Credited Service* required by your Plan and Tier.

You vested, retired, or received a refund of your contributions which terminated your membership.

## WHAT HAPPENS ONCE NYCERS RECEIVES MY APPLICATION, AND HOW IS IT PROCESSED?

Once NYCERS receives your properly completed and notarized disability retirement application, NYCERS will:

1. Verify your eligibility to make application or ask your employing agency to verify your employment status.
2. Ask hospitals and health centers to provide a medical history, if you have completed Form # 608.
3. Verify that your case file, including medical records, is complete. (The processing of your case will be suspended or closed, if medical evidence is insufficient.)
4. Schedule you to appear before NYCERS' Medical Board for a medical interview and/or examination. (Confirm your appointment at least 7 days in advance by calling (347) 643-3000, press 8, then 1)

(continued on page 2)

**Note:** Failure to appear for your appointment before NYCERS' Medical Board, without medical proof that you were unable to do so, will result in official suspension of your disability retirement application. Depending on your employment status, you may not be eligible to reapply for disability retirement.

- NYCERS' Medical Board will review your medical file, conduct an interview and examination, and make its determination.

### WHAT HAPPENS AFTER I AM INTERVIEWED AND/OR EXAMINED BY THE MEDICAL BOARD?

NYCERS' Medical Board will make a recommendation to approve, deny, or defer a decision on your application.

You can call NYCERS Medical Division for the Medical Board's recommendation based on the following schedule:

If you appear before the Medical Board on:	Call NYCERS at (347) 643-3000 Press 8 then 1 for the Medical Board's recommendation after 2:00 p.m. on:
Monday	Wednesday
Tuesday	Thursday
Wednesday	Friday
Thursday	Monday
Friday	Tuesday

You will also receive confirmation of the Medical Board's recommendation in writing.

### WHAT HAPPENS IF THE MEDICAL BOARD RECOMMENDS APPROVAL OF MY DISABILITY APPLICATION?

NYCERS will ask your agency to verify the last day you worked and the last day you were paid, if not previously provided. Upon receipt, NYCERS will establish a retirement date, calculate your advance payment, and send you a letter advising you of the amount.

### IF THE MEDICAL BOARD DETERMINES I AM DISABLED, WHEN DO I RECEIVE A BENEFIT CHECK?

NYCERS normally issues an advance payment between 60 and 90 days from the time you are notified of the Medical Board's approval of your application.

Approximately 90 days after you receive your first advance payment, you will receive a letter advising you of the final amount payable to you under the various options, and a description of your benefit options.

### WHAT HAPPENS IF THE MEDICAL BOARD DENIES MY APPLICATION FOR DISABILITY RETIREMENT?

After NYCERS' Board of Trustees accepts the Medical Board's recommendation to deny your application, you may elect a review by a Special Medical Review Committee of three independent doctors. (Uniformed Correction Officers are not eligible for Medical Review.)

**Note:** Your union or employer must make a request, to the Executive Director of NYCERS, for you to appear before the Special Medical Review Committee. This election binds you to the Committee's decision. You also waive your rights to reapply for a disability retirement, and to challenge the decision in court (Article 78 relief).

Members who do not elect final medical review may reapply for disability retirement by filing another application and submitting current medical evidence not previously reviewed by the Medical Board.

Members must remain on their agency's payroll (with or without pay) in order to maintain their eligibility to refile.

You also have the right to appeal non-medical issues relating to a denial of your disability retirement application. Requests to appeal must be in writing.

NYCERS' Board of Trustees does not have the authority to make medical decisions, or to overrule medical decisions of the Medical Board. NYCERS' Trustees do make decisions about whether a disability is caused by an accident, or whether an incident is an accident.

### WHAT HAPPENS IF THE MEDICAL BOARD DEFERS ITS DECISION?

NYCERS will notify you of the deferral and ask you to provide additional information or appear for an evaluation before an independent medical consultant.

You are required to provide all information or appear for evaluation, within 45 days of the date of the NYCERS' Medical Board letter. If you do not, your application will be suspended.

### CAN AN APPLICATION FOR ORDINARY OR ACCIDENT DISABILITY RETIREMENT BE WITHDRAWN?

If NYCERS Medical Board has not finalized its findings, you may withdraw your application for a disability retirement benefit upon written request to NYCERS and approval of the Medical Board.



### ARE THERE ANY LIMITATIONS ON INCOME EARNED WHILE I COLLECT A DISABILITY RETIREMENT BENEFIT?

Pensioners are subject to limits on the income they earn while collecting disability retirement benefits.

For disability retirees who have reached normal retirement age, there are no limitations on earnings from:

- Private sector employment
- Federal government employment
- Any public service employment outside the State of New York

Limitations apply at certain income thresholds. In addition to the limitations on your income, other rules may apply to your employment while you are disabled. Before accepting employment, you should write or visit NYCERS to determine whether you are subject to income limitations.

### AM I REQUIRED TO REPORT TO NYCERS ANY INCOME I EARN WHILE COLLECTING MY DISABILITY RETIREMENT BENEFIT?

Yes. Once each year, (until you reach normal retirement age) you will be required to complete and return to NYCERS, the New York City Employees' Retirement Safeguards Information Affidavit disclosing your income during the preceding calendar year.

### WHAT HAPPENS IF I AM NO LONGER DISABLED AND WANT TO RETURN TO WORK?

Members retired by reason of disability for one year or more may request a Medical Board re-examination to establish their ability to return to work.

In some cases, the Medical Board may approve a disability retirement application contingent on re-examination at a later date. By law, each year, until you reach normal retirement age, you may be required to be re-examined by NYCERS Medical Board.

If, upon re-examination, the Medical Board determines that you are no longer disabled, the Department of Citywide Administrative Services will place your name on a list of preferred eligible candidates for appointment to a position in a salary grade not exceeding that from which you retired. Disability benefits will continue to be paid until you are offered a job. If you return to work, or fail to return to work when called, NYCERS will discontinue payment of your disability benefit.

**Note:** To be restored to active NYCERS' membership, please notify NYCERS' Pension Payroll Division immediately upon your return to work. Failure to do so may jeopardize your rights to future retirement benefits.

### ARE THERE TAX CONSEQUENCES ON DISABILITY RETIREMENT BENEFITS I RECEIVE?

Ordinary and accident disability retirement benefits are not subject to New York State and local income taxes. Ordinary disability retirement benefits are subject to Federal income tax.

Members who receive a ¾ accidental disability retirement benefit are not subject to Federal tax on their benefit.

### WILL I GET A REDUCTION IN BENEFIT BECAUSE OF OTHER GOVERNMENT BENEFITS I MAY RECEIVE?

There is no reduction in benefit because of any Social Security payments.

Accident disability retirement benefits are reduced by 100% of any workers' compensation payments you receive.

### WHO ADMINISTERS MY HEALTH INSURANCE COVERAGE?

**NYCERS does not administer health insurance benefits.**

Ask your agency's personnel or human resources department about active employees' health insurance.

Questions regarding retirees' health insurance benefits and deductions should be directed to the following:

<b>NYC Office of Labor Relations:</b>	<b>(212) 513-0470</b>
<b>NYC Transit Authority:</b>	<b>(646) 376-0123</b>
<b>TBTA:</b>	<b>(646) 252-7935</b>



# Disability Retirement Tier 1 & Tier 2 Eligibility Requirements

PLAN	ORDINARY DISABILITY ELIGIBILITY BY YEARS OF SERVICE
Tier 1 Plans A & B Tier 2 Plans C & D Tier 1 Fractional	Ten or more years of <i>Membership Service</i> <b>and</b> while a member on payroll (with or without pay)
Tiers 1 & 2 Uniformed Sanitation Force	Five or more years of <i>Allowable Sanitation Service</i> <b>and</b> while a member on payroll (with or without pay)
Tiers 1 & 2 Transit Operating	Ten or more years of <i>Membership Service</i> <b>and</b> while a member on payroll (with or without pay)
Tiers 1 & 2 Uniformed Correction Force	No minimum service requirement, provided a member is on payroll (with or without pay)

**There are no minimum service requirements for Accidental Disability Retirement**

**Note:** Terms in italics are defined in the Summary Plan Description for your Tier and Program. Terms which sound alike may have different definitions in the various Tiers and Programs.

## Ordinary Disability Retirement Effective Date & Filing Requirements

PLAN	EFFECTIVE DATE	FILING REQUIREMENTS
Tier 1 Plans A & B Tier 2 Plans C & D Tiers 1 & 2 Uniformed Sanitation Force Tiers 1 & 2 Transit Operating Force	Day after last day paid on employer's payroll, but not less than 30 days, or more than 90 days after the date application was filed with NYCERS.	You or another person acting on your behalf <b>or</b> A committee or conservator duly appointed by a court of competent jurisdiction <b>or</b> The head of the agency where you are employed  You must be on your agency's payroll (with or without pay) when your application is filed and while it is pending.
Tiers 1 & 2 Uniformed Correction Force	Day after last day paid on your employer's payroll.	

## Accidental Disability Retirement Effective Date & Filing Requirements

PLAN	EFFECTIVE DATE	FILING REQUIREMENTS
Tier 1 Plans A & B Tier 2 Plans C & D Tiers 1 & 2 Uniformed Sanitation Force Tiers 1 & 2 Transit Operating Force	<b><u>Later of:</u></b>  The date the application is filed <b>or</b> The date immediately following the date you were last paid on your employer's payroll.	You or another person acting on your behalf <b>or</b> A committee or conservator duly appointed by a court of competent jurisdiction <b>or</b> The head of the agency where you are employed  You must be on your agency's payroll (with or without pay) when your application is filed and pending.  <b>Additional requirement for Tier 1 Plans A&amp;B, Tier 2 Plans C&amp;D, and Tiers 1 and 2 Transit Operating Force:</b> Application must be filed within 2 years from date of accidental injury in City service. If application is denied because you were not incapacitated for performance of regular job duties at time of examination, you may reapply for reconsideration at any time within 5 years of accidental injury in City service, provided you have not attained age 55 for Tier 1 members, age 62 for Tier 2 members, or age 50 for Tiers 1 and 2 Transit Operating Force members.
Tiers 1 & 2 Uniformed Correction Force	The day after last day paid on employer's payroll.	You or another person acting on your behalf <b>or</b> A committee or conservator duly appointed by a court of competent jurisdiction <b>or</b> The head of the agency where you are employed. You must be on your agency's payroll (with or without pay) when your application is filed and while it is pending.