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.
Application for Disability Retirement

Members of Tier 4, and Tier 4 with Tier 3 Rights

This application is for Tier 4 members and Tier 4 members with Tier 3 rights who wish to apply for a Disability Retirement. In order for the New York City Employees’ Retirement System (NYCERS) to process this application, this form must be filled out in its entirety. Please be sure you read and understand the requirements for filing for a Disability Retirement found on the Instructions and Terms pages. NOTE: If the address you provide on this form is different from your address on file with NYCERS, the new address will become your official address in NYCERS’ records. If you have any questions, contact NYCERS’ Call Center at 347-643-3000.

In addition to this form, you must also submit to NYCERS:
- Physician’s Report of Disability (Form #606)
- General Authorization for Release of Medical Information (Form #608)
- NYCERS Questionnaire (Form #609)

Select a Benefit:

Be sure to read the requirements on the Instructions and Terms pages to determine which you qualify under. All applications will be processed according to the benefit(s) selected below.

I am applying for (Mark all that apply):

- Disability Retirement with 10-years Service, or as the Result of an Accident (RSSL §605)
- Uniformed Sanitation ¾ Accident Disability (RSSL §605-b)
- Uniformed Sanitation Heart Law (GML §207-r)
- Deputy Sheriffs ¾ Accident Disability (RSSL §605-c)
- World Trade Center (WTC) Disability Retirement

RSSL = Retirement and Social Security Law  GML = General Municipal Law  EMT = Emergency Medical Technician

Select a Benefit:

Be sure to read the requirements on the Instructions and Terms pages to determine which you qualify under. All applications will be processed according to the benefit(s) selected below.

I am applying for (Mark all that apply):

- EMT Heart Law (GML §207-q)
- EMT ¾ Performance-of-Duty Disability (RSSL §607-b)
- Tier 4 with Tier 3 Rights, Social Security Dependent Ordinary Disability (RSSL §506)
- Tier 4 with Tier 3 Rights, Social Security Dependent Accident Disability (RSSL §507)

Member Information:

<table>
<thead>
<tr>
<th>Member Number</th>
<th>Last 4 Digits of SSN</th>
<th>Phone Number</th>
<th>Date of Birth [mm/dd/yyyy]</th>
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First Name     M.I.     Last Name

Address         Apt. Number

City            State      Zip Code

Email Address

Agency          Title

List your Disabling Conditions:

The conditions listed on this form are the only conditions the Medical Board will consider under this application.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
Select a Temporary Option

This application allows you to select a temporary option, which determines what will happen to your benefit if you should die before the date of your first full payment (the “Interim Period”). If you select either the 100% Joint-and-Survivor or the Ten-Year Certain Option, you must name a beneficiary. If you die before selecting an option, or if you fail to name a beneficiary, NO DEATH BENEFIT WILL BE PAYABLE FROM NYCERS.

Please read the descriptions for each option before choosing only one temporary option. Note: Only Tier 4 members with Tier 3 Rights may nominate their Estate as primary OR contingent beneficiary for the Ten-Year Certain Option. Tier 4 members may only nominate their Estate as a contingent beneficiary for the Ten-Year Option.

- If you choose the Maximum Retirement Allowance, do not name a beneficiary.
- If you choose the 100% Joint-and-Survivor Option, you may designate only one beneficiary. Under this option, NYCERS requires proof of birthdate for your beneficiary, as well as additional valid documentation, such as a marriage certificate(s), for all names that your beneficiary has been known by that are different from the name on the birthdate evidence you submit.
- If you choose the Ten-Year Certain Option, you may designate one primary and two contingent beneficiaries on this form. If space is needed for additional contingent beneficiaries, contact NYCERS’ Call Center at 347-643-3000. Under this option, birthdate evidence for your beneficiary(ies) is not required.
- If you wish to select an option other than those provided on this form, contact NYCERS’ Call Center at (347) 643-3000.

Choose Only ONE Option:

Please provide information about your beneficiary(ies) following the option you have elected (except Maximum). Print neatly and in ink. Use your beneficiary’s given name (Mary Smith, not Mrs. John Smith). DO NOT erase, use white-out, or cross out any typed or printed information on this form, as it renders the form invalid.

☐ Maximum – I elect to receive the maximum lifetime retirement allowance payable to me. I understand that all payments cease upon my death, and that under this option I cannot elect a beneficiary.

☐ OR –

☐ 100% Joint-and-Survivor – This temporary option provides your designated beneficiary with a lifetime benefit if you die during the Interim Period. The benefit is calculated as if you had elected the 100% Joint-and-Survivor Option as your permanent option. Among the factors considered in the calculation are the life expectancies of both you and your designated beneficiary. Under this option, you receive a reduced pension (a pension lower than the Maximum Retirement Allowance) because the same amount is to be paid over two lifetimes. In this case, the benefit payable to your beneficiary for his or her lifetime would be 100% of the reduced pension you would have received during your lifetime. You may not nominate your Estate for this option.

The beneficiary whom I wish to nominate to receive the 100% Joint-and-Survivor benefit is:

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<th>First Name</th>
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<th>Full Social Security Number</th>
<th>Date of Birth [mm/dd/yyyy]</th>
<th>Relationship</th>
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☐ If this beneficiary is a minor, you have the option to name a guardian of the property of the minor by checking this box and completing Form #137. (See Instructions page for details.)

Or Non Joint-and-Survivor Option, Next page...
Member Number | Last 4 Digits of SSN

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**- OR - NON JOINT-AND-SURVIVOR OPTION**

☐ **Ten-Year Certain** – Under this option, if you die within ten years of your retirement, the reduced monthly retirement benefit will be paid to your surviving primary beneficiary for the unexpired balance of the ten-year period. If the designated primary beneficiary predeceases you, the balance of the payment continues to your contingent beneficiary. If none exists, it is paid in a lump-sum to your Estate. Should a primary beneficiary die after receiving payments, the balance will be paid to the estate of the primary beneficiary. You may nominate both a primary and contingent beneficiary(ies) under this option.

**Section A - Designation of Estate for Ten-Year Certain as Primary Beneficiary.** (Tier 4 members with Tier 3 Rights ONLY. Check the box and leave Section B blank.)

☐ I am nominating my Estate as my sole beneficiary. I understand that by checking this box, the benefit payable under the Ten-Year Certain Option will be payable to my Estate in a lump sum. In order for this selection to be valid, I may not write in any other beneficiary’s name on this form, and I have, in fact, left all other designation of beneficiary sections on this form blank.

**Section B - Designation of individuals as beneficiary(ies) to receive the Ten-Year Certain benefit.**

The beneficiary(ies) whom I wish to nominate to receive the Ten-Year Certain benefit is/are:

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<th>First Name</th>
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<th>Last Name</th>
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<table>
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<tr>
<th>Full Social Security Number</th>
<th>Date of Birth [mm/dd/yyyy]</th>
<th>Relationship</th>
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<tr>
<th>Address</th>
<th>Apt. Number</th>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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</table>

☐ If this beneficiary is a minor, you have the option to name a guardian of the property of the minor by checking this box and completing Form #137. (See Instructions page for details.)

**Note:** If naming multiple contingent beneficiaries, indicate the share of the benefit you would like each to receive. The combined percentage for all contingents named must equal 100%. **You may name your Estate as a contingent beneficiary.**

<table>
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<tr>
<th>First Name/Estate Name</th>
<th>M.I.</th>
<th>Last Name</th>
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<tr>
<th>Full Social Security Number</th>
<th>Date of Birth [mm/dd/yyyy]</th>
<th>Relationship</th>
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<tr>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

☐ If this beneficiary is a minor, you have the option to name a guardian of the property of the minor by checking this box and completing Form #137. (See Instructions page for details.)

**Share of Benefit %**

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**Space for an additional contingent beneficiary on next page.**
Mail Completed Forms to:
30-30 47th Avenue, 10th Fl
Long Island City, NY 11101

Member Number Last 4 Digits of SSN

Additional Contingent Beneficiary for Ten-Year Certain Option:

First Name/Estate Name M.I. Last Name

Full Social Security Number Date of Birth [mm/dd/yyyy] Relationship

Address Apt. Number

City State Zip Code

☐ If this beneficiary is a minor, you have the option to name a guardian of the property of the minor by checking this box and completing Form #137. (See Instructions page for details.)

NOTE: If space is needed for additional contingent beneficiaries, contact NYCERS’ Call Center at 347-643-3000.

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:

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

☐ 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

☐ 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

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.

Signature of Notary Public or Commissioner of Deeds

Official Title

Expiration Date of Commission

If you have an official seal, AFFIX IT

Sign this form and have it notarized, THIS PAGE.
Instructions

To apply for a Disability Retirement, complete this application together with Form #606 - Physician’s Report of Disability, Form #608 - General Authorization for Release of Medical Information, and Form #609 - NYCERS Questionnaire, and submit them to NYCERS.

If you are submitting these forms by mail, have this application acknowledged before a Notary Public or Commissioner of Deeds, and mail it to 30-30 47th Avenue, 10th Floor, Long Island City, NY 11101. Forms #606, #608, and #609 do not require a notary, but if submitting by mail, send them to NYCERS’ Medical Unit, 335 Adams Street, Suite 2300, Brooklyn NY 11201-3724.

If you are submitting these forms in person to NYCERS’ Walk-in Center, and can show a valid photo identification, Form #604 does not need to be notarized. The Walk-in Center is located at 340 Jay Street, Mezzanine Level, in downtown Brooklyn.

NYCERS’ Medical Unit will inform you about your Medical Board examination date.

If the Medical Board finds you disabled, and recommends retirement, the Medical Board report 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 a final option. If you fail to select a final option in the period prescribed, you will be awarded the temporary option you selected when filing for Disability Retirement. If you choose not to select a temporary option, or your selection has been deemed invalid, 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 with your rights and remedies as a result of the denial.

Form #137 - Designation of Guardian When Designating a Minor as Beneficiary

If your beneficiary is a minor (under the age of 18) at the time of your death, a guardian of the property of the minor is needed for NYCERS to pay out a benefit. You have the option to designate a guardian of property for your minor beneficiary by filing Form #137.

If you do not wish to designate a guardian, and the minor does not turn 18 prior to your death:

- The minor will either wait until their 18th birthday to receive any benefit; OR
- A guardian of the property will need to be appointed by the Surrogate Court before the minor will be permitted to receive any benefit.

Filing Requirements for RSSL §605 and §605-b

You must file an application for a Disability Retirement benefit:

1. within three months from the last date you were being paid on the payroll; OR
2. while you are on a leave of absence without pay for medical reasons, either voluntarily or involuntarily; OR
3. no later than 12 months after the date you receive notice that your employment has been terminated, provided that you were on an approved leave of absence without pay for medical reasons, which was in effect immediately prior to such termination.

The application must be filed by you, or by a person with legal authority to act on your behalf, or by the head of the agency where you are employed.

Disability Retirement with 10-years Service, or as the Result of an Accident (RSSL §605):

If you have 10 or more years of Credited Service and NYCERS’ Medical Board determines that you are unable to perform the duties of your job title due to a physical or mental impairment, you are eligible to receive a Disability Retirement benefit. If you have less than 10 years of Credited Service and NYCERS’ Medical Board determines that you are disabled as a natural and proximate result of an accidental injury sustained in City service, not caused by your own willful negligence, you are eligible to receive a Disability Retirement benefit.

EMT ¾ Performance-of-Duty Disability (RSSL §607-b):

EMTs who become incapacitated for the performance of duties on or after March 17, 1996 as the natural and proximate result of an injury sustained while employed as an EMT are entitled to a Performance-of-Duty Disability benefit. You may also apply under this section if you are presumed to have contracted HIV (through the bodily fluids of a person under care), tuberculosis or hepatitis while in the performance of your duties. You must file this application while you are actually employed in the eligible title.

EMT Heart Law (GML §207-q):

The Heart Law provides a rebuttable presumption that a disease of the heart was incurred in the performance of duty. EMTs who are approved for disability under the Heart Law are entitled to a Performance-of-Duty Disability benefit. The presumption may be rebutted by competent medical evidence that your disability could not have been caused by the performance of your duties as an EMT. You must file this application while you are actually employed in the eligible title.

Uniformed Sanitation ¾ Accident Disability (RSSL §605-b):

A Uniformed Sanitation member is eligible to apply for Accident Disability if he or she becomes incapacitated for the performance of duty as a natural and proximate result of an accidental injury sustained in service while a Uniformed Sanitation member, not caused by his or her own willful negligence. An application must be filed within two years after the occurrence of the accident.
Uniformed Sanitation Heart Law (GML §207-r): The Heart Law provides a rebuttable presumption that a disease of the heart was incurred in the performance of duty. Uniformed Sanitation members who are approved for disability under the Heart Law are entitled to an Accident Disability benefit. The presumption may be rebutted by competent medical evidence that your disability could not have been caused by the performance of your duties as a Sanitation Worker.

Deputy Sheriffs ¾ Accident Disability (RSSL §605-c): NYC Deputy Sheriffs who become physically or mentally incapacitated for the performance of duties as the natural and proximate result of an accident, not caused by their own willful negligence, are entitled to an Accident Disability benefit. You must file this application while you are actually employed in the eligible title.

NOTE: In addition to applying under the special disability provisions above, Uniformed Sanitation members, Deputy Sheriffs and EMTs may also apply for Disability Retirement under RSSL §605 if they have 10 or more years of Credited Service.

TIER 4 MEMBERS WITH TIER 3 RIGHTS (joined NYCERS between July 27, 1976 and August 31, 1983)

Requirements for Social Security Dependent Ordinary Disability Retirement Benefits under RSSL §506:

1. You must have at least five years of service credit.
2. You must file this application during a pay period for which you were entitled to a regular paycheck for your City service or no later than two (2) years after the commencement of an authorized leave of absence for medical reasons, which has continued to be in effect since you were last paid on the payroll.
3. You must be found eligible to receive primary Social Security Disability benefits.

NOTE: You will be required to submit proof to NYCERS within 60 days from the date of this application that you have applied for primary Social Security Disability benefits. NYCERS will hold your application open for a maximum of two years pending a Social Security Disability award. If you receive a primary Social Security Disability award, you must notify NYCERS within the earlier of:
   a. sixty days after the date of Social Security Administration award; OR
   b. the two-year period described above, or as extended by any appeals.

If you do not follow these procedures, you will not be eligible to receive disability benefits under RSSL §506.

Requirements for Social Security Dependent Accident Disability Retirement Benefits under RSSL §507:

1. You must file this application during a pay period for which you are entitled to a regular paycheck for your City service.
2. You must be found eligible to receive primary Social Security Disability benefits, and the disability must be found to be the natural and proximate result of an accident sustained in active service.
3. If applying under RSSL §507 and you have not yet applied for primary Social Security Disability benefits, you will be required to submit proof to NYCERS, within 60 days of this application, that you have applied for such benefits. NYCERS will hold your application open for a maximum of two years pending a Social Security Disability award (extended by any time necessary to complete any and all appeals).
4. You must notify NYCERS within the shorter of:
   a. sixty days after the date of Social Security Administration award; OR
   b. the two-year period described above, or as extended by any appeals.

World Trade Center (WTC) Disability Retirement Law

The World Trade Center (WTC) Disability Law provides a rebuttable 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 WTC Disability Law Fact Sheet #703, available on NYCERS’ website at www.nycers.org.

Workers’ Compensation Payments Offset

Disability Retirement benefits under RSSL §506, §507, §605-c, §607-b, and GML §207-q are subject to an offset of 100% of any Workers’ Compensation payments received on account of the same injury for which the Disability Retirement benefits were approved.

NOTE: Uniformed Sanitation Force members do not receive Workers’ Compensation and therefore are not subject to offsets.

Withdrawing an Application for Disability Retirement

You may withdraw your application for a Disability Retirement benefit by submitting Form #619 - Withdrawal of Disability Retirement Application to NYCERS’ Medical Unit. This application can be withdrawn up to and until the Medical Board has finalized its findings on your application. You may not withdraw an application filed by your agency on your behalf.

Returning to Work

Disability retirees who are returning to public service within New York City or New York State may be subject to post-retirement earning limitations. For complete details, please see NYCERS’ Brochure #958 - Earnings Limitations for Disability Retirees.
Designation of Beneficiary(ies)
Post-Retirement Lump-Sum Death Benefit

This application is for those who wish to nominate a beneficiary(ies) to receive a post-retirement lump-sum death benefit. If the designated Primary Beneficiary(ies) predeceases you, the lump-sum payment will be paid to your designated Contingent Beneficiary(ies). If none exists, the lump-sum benefit will be paid to your estate. **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.** If you have any questions, contact our Call Center at 347-643-3000.

I understand that at the time of my death after retirement, the lump-sum death benefit will be paid to my surviving designated Primary Beneficiary(ies). If the designated Primary Beneficiary(ies) predeceases me, the lump-sum death benefit will be paid to my designated Contingent Beneficiary(ies). If none exists, the lump-sum death benefit will be paid to my estate.

I, the undersigned, nominate as my beneficiary(ies) for the lump-sum death benefit payable on my death after retirement:

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<thead>
<tr>
<th>Primary Beneficiary</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>First Name</td>
<td>M.I.</td>
</tr>
<tr>
<td>Full Social Security Number</td>
<td>Date of Birth [MM/DD/YYYY]</td>
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<tr>
<td>Address</td>
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<td>City</td>
<td>State</td>
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If this beneficiary is a minor, check here and complete the guardian information on **Form 137**

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<tr>
<th>Second Primary Beneficiary</th>
<th>Percentage</th>
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<tr>
<td>First Name</td>
<td>M.I.</td>
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<tr>
<td>Full Social Security Number</td>
<td>Date of Birth [MM/DD/YYYY]</td>
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<td>Address</td>
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<tr>
<td>City</td>
<td>State</td>
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</table>

If this beneficiary is a minor, check here and complete the guardian information on **Form 137**
Mail completed form to:
30-30 47th Avenue, 10th Fl
Long Island City, NY 11101

Member Number OR Pension Number Last 4 Digits of SSN

If the foregoing Primary beneficiary(ies) should predecease me, I hereby nominate the following as Contingent beneficiary(ies) for the above Post-Retirement Lump-Sum Death Benefit.

First Name M.I. Last Name

Full Social Security Number Date of Birth [MM/DD/YYYY] Relationship

Address Apt. Number

City State Zip Code

[ ] If this beneficiary is a minor, check here and complete the guardian information on Form 137

Percentage 

I am nominating my Estate as my beneficiary for my post-retirement lump-sum death benefit. I understand that in order for this selection to be valid I may not write in any other beneficiary's name on this form, and I have, in fact, left all other designation of beneficiary sections on this form blank.

Should I survive all designated beneficiaries, the post-retirement lump-sum death benefit shall be paid to my Estate or to such other beneficiary or beneficiaries as I shall hereafter nominate by filing another designation of beneficiary form with NYCERS.

Signature of Member Date

(Witnesses necessary only if mark is used for signature)

Witnessed by (1):

Witnessed by (2):

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

State of County of On this day of 2 0 

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.

Signature of Notary Public or Commissioner of Deeds

Official Title

Expiration Date of Commission

I have an official seal, affix it

Sign this form and have it notarized, THIS PAGE
To be returned to NYCERS with member's application for disability retirement

To NYCERS' Medical Board:
This is to certify that

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<th>M.I.</th>
<th>Last Name</th>
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an employee in the New York City Department of

is under my care for the following:

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

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

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<th>Date [MM/DD/YYYY]</th>
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When, if ever, may he or she return to the full duties of his or her title?

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<th>Date [MM/DD/YYYY]</th>
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</table>

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

**Subjective evidence:**
Symptoms, Complaints, Etc.

**Treatment and result:**
<table>
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<tr>
<th>Member Number</th>
<th>Last 4 Digits of SSN</th>
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<tr>
<th>Physician First Name</th>
<th>Physician Last Name</th>
<th>Title (MD, DO, DC etc.)</th>
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**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**

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<th>First Name</th>
<th>M.I.</th>
<th>Last Name</th>
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**in Care of (if applicable)**

**Full Social Security Number**

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</table>
General Authorization for Medical Information

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 ____________________________

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission on Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of health provider or entity to release this information:

__________________________________________________________________________________________________

8. Name and address of person(s) or category of person to whom this information will be sent:

__________________________________________________________________________________________________

9(a). Specific information to be released:

☐ Medical Record from (insert date) __________ to (insert date) __________

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consents, billing records, and records sent to you by other health care providers.

☐ Other: __________________________________________________________________________________________

Include: (Indicate by Initialing)

_____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV-Related Information

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.
Authorization to Discuss Health Information:

9(b). [ ] By initialing here _________ I authorize __________________________ 

Name of individual health care provider 

Initials __________________________________________________________________

__________________________

(Attorney/Firm Name or Governmental Agency Name) 

to discuss my health information with my attorney, or a governmental agency, listed here:

__________________________

10. Reason for release of information: [ ] At request of individual [ ] Other: __________________________

11. Date or event on which this authorization will expire: __________________________

12. If not the patient, name of person signing form: __________________________

13. Authority to sign on behalf of patient: __________________________

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

Signature of Member or Representative authorized by law __________________________ Date __________________________

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 __________________________

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional.

When filling out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date."

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked and the relevant date inserted on the first line containing the first box.
Questionnaire for Disability Retirement Applicants

<table>
<thead>
<tr>
<th>Member Number</th>
<th>Last 4 Digits of SSN</th>
<th>Phone Number</th>
<th>Date of Birth [mm/dd/yyyy]</th>
</tr>
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<tbody>
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To NYCERS’ Medical Board:

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

Your Job Title

in the Department of

Your Agency
due to the disabling conditions listed on my Application for Disability Retirement.

Questions 1-17 are to be completed by ALL members applying for Disability Retirement.

1. What is the name of your union, and local?

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

   ☐ Yes ☐ No

   If yes, provide a start date and an end date for each period of service:

<table>
<thead>
<tr>
<th>Period of Service</th>
<th>Start Date</th>
<th>End Date</th>
<th>Period of Service</th>
<th>Start Date</th>
<th>End Date</th>
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<td>_____ / _____</td>
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3. Are you a veteran?

   ☐ Yes ☐ No

   If yes, name the branch(es) you served in, and provide a start and end date for each period of service:

<table>
<thead>
<tr>
<th>Branch of Service</th>
<th>Start Date</th>
<th>End Date</th>
<th>Branch of Service</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
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</tbody>
</table>
Member Number Last 4 Digits of SSN

4. List the name(s) of doctors or institutions from whom you are receiving, or have received in the past, treatment for your alleged conditions, including address(es) and frequency of visits:

<table>
<thead>
<tr>
<th>Name of Doctor or Institution</th>
<th>Address</th>
<th>Frequency of Visits</th>
</tr>
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<tbody>
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Note: The Physician's Report of Disability must be completed by each doctor listed above and submitted with your application.

5. When did your symptoms begin?

Month / Day / Year

6. List the nature of treatment, including medications being taken:

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Medication</th>
<th>Frequency</th>
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7. Check boxes below to indicate tests performed (submit a copy of ALL REPORTS, if possible):

- Blood and Urine
- EKG (Electrocardiogram)
- Stress Test
- Other
- X-Rays
- Myelogram
- Pathology or Biopsy Reports
- EMG (Electromyogram)
- CT scan
- Pulmonary Function studies
8. I have been hospitalized and/or treated for this condition at the following hospital(s) and/or medical group(s):

<table>
<thead>
<tr>
<th>Name of Hospital/ Medical Group</th>
<th>Address</th>
<th>Date of Admission</th>
<th>Date of Discharge</th>
<th>Diagnoses</th>
<th>Was surgery performed?</th>
</tr>
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<td>☐ Yes ☐ No</td>
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</tbody>
</table>

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.

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

☐ Yes ☐ No

10. Are you working now?

☐ Yes ☐ No

If no, when did you stop?

Month / Day / Year
Member Number  Last 4 Digits of SSN

11. Did you file for Social Security Disability Benefits?
   ☐ Yes   ☐ No

12. Are you receiving Social Security Disability payments?
   ☐ Yes   ☐ No

   If Yes, how much monthly?
   $ _______________________

13. Did you file a Workers’ Compensation claim?
   ☐ Yes   ☐ No

14. Are you receiving Workers’ Compensation payments?
   ☐ Yes   ☐ No

   If Yes, how much bi-weekly?
   $ _______________________

15. Do you drink alcohol?
   ☐ Yes   ☐ No

   If Yes, how often?
   _______________________

   How much?
   _______________________

16. Do you take any medications daily?
   ☐ Yes   ☐ No

   If Yes, what?
   _______________________

   _______________________

17. Do you use any recreational drugs?
   ☐ Yes   ☐ No

   If Yes, what and how often?
   _______________________

   _______________________

If you are NOT filing for accidental disability, skip to page 6 and sign.
Questions 18-33 are to be completed ONLY by members applying for Disability Retirement as a result of an incident that occurred while performing their job duties while in City service, or who have filed for a Performance-of-Duty Disability Retirement.

18. What is the date that the injury occurred?

Month / Day / Year

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 were you doing when you were injured?

____________________________________________________

____________________________________________________

____________________________________________________

22. What part of your body was injured?

____________________________________________________

____________________________________________________

____________________________________________________

23. How were you injured?

____________________________________________________

____________________________________________________

____________________________________________________

24. Were there any witnesses to the incident when you were injured?

☐ Yes  ☐ No

If Yes, give Name, Title and Address (if known):

____________________________________________________

____________________________________________________

____________________________________________________

25. When did you stop working because of the injury?

Month / Day / Year

26. Do you have proof of this occurrence?

☐ Yes  ☐ No

If Yes, submit supporting documentation with this questionnaire.

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

Date

Month / Day / Year

By whom? ______________________________

Place? ______________________________
Mail Completed Form to:
335 Adams Street, Suite 2300
Brooklyn, NY 11201-3724

Member Number Last 4 Digits of SSN

28. List the name(s) of doctors or institutions who treated you for the injury described, including address(es) and frequency of visits:

<table>
<thead>
<tr>
<th>Name of Doctor or Institution</th>
<th>Address</th>
<th>Frequency of Visits</th>
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29. Have you had any similar disability before the incident?
   Yes [ ]
   No [ ]

30. Have you had any other accidents or incidents on the job (either before or after the incident claimed herein)?
   Yes [ ]
   No [ ]

   If Yes, give dates and description of injury:
   Start date:
   End date:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
<th>Description</th>
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31. Have you had any accidents or injuries off the job?
   Yes [ ]
   No [ ]

   If Yes, give dates and description of injury:
   Start date:
   End date:

<table>
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<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
<th>Description</th>
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32. Did you return to light duty after the incident herein claimed?
   Yes [ ]
   No [ ]

   If Yes, when?
   Start date: [Month] / [Day] / [Year]
   End date: [Month] / [Day] / [Year]

33. Did you return to full duty after the incident herein claimed?
   Yes [ ]
   No [ ]

   If Yes, when?
   Start date: [Month] / [Day] / [Year]
   End date: [Month] / [Day] / [Year]

I will appear before NYCERS’ Medical Board at 340 Jay Street, Mezzanine Level, in downtown Brooklyn when I am scheduled 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
Correction Officers who became members of NYCERS after 07/27/76 are members of Tier 3. All other employees who became members after that date are members of Tier 4.

Note: Non-Correction Officers who became members on or after 07/27/76, and on or before 08/31/83, are Tier 4 members with Tier 3 rights.

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

Members are eligible for a benefit for disability retirement not based on a service retirement benefit formula if they have 10 or more years of Credited Service, of which 5 years must be Membership Service.

Members with less than 10 years of Credited Service may be eligible to apply for disability retirement based on a service connected accident which occurred in the performance of City service.

The courts have defined the term accident as a “sudden, fortuitous mishance, unexpected, out of the ordinary, and injurious in impact.” Not every line of duty injury is determined to be an accident.

What is Disability Retirement?

You must complete and submit the following NYCERS forms:

- Application for Ordinary Disability Retirement or Accidental Disability Retirement (Form # 603 for Tier 3 members; Form # 604 for Tier 4 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.

Tier 3 Members And Tier 4 Members With Tier 3 Rights:

You must submit proof of filing for a Primary Social Security Disability Award within 60 days of applying for disability retirement with NYCERS. In order to receive your payment, you must submit your Social Security Administration Award letter within 60 days of its receipt.

Disqualifying Conditions:

You did not submit your application for disability retirement on a timely basis (see back page).

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

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

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 Unit receives the items above and determines your eligibility. If you are not eligible, you will be notified in writing of the reason.
**What Happens Once NYCERS Receives My Application, And How Is It Processed?**

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

1. Verify your eligibility to make application and 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.)

   **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.
5. Provide for a Medical Board review of your current files, and an interview and examination. The Medical Board will then 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 Unit for the Medical Board’s recommendation based on the following schedule:

<table>
<thead>
<tr>
<th>If you appear before the Medical Board on:</th>
<th>Call NYCERS at (347) 643-3000 Press 8 then 1 for the Medical Board’s recommendation after 2:00 p.m. on:</th>
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<tbody>
<tr>
<td>Monday</td>
<td>Wednesday</td>
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<td>Tuesday</td>
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<td>Monday</td>
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<td>Friday</td>
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</table>

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, process 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 processes your case for an advance payment within 60 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 amounts payable to you under various options, and a description of your benefit under the options available to you.

**What Happens If The Medical Board Recommends Denial Of My Application For Disability Retirement?**

After the Board of Trustees accepts the recommendation of the Medical Board 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 are still eligible may reapply for disability retirement by filing another application and submitting current medical evidence not previously reviewed by the Medical Board.

If a member is beyond the one-year-termination limit, he/she must refile within 60 days of the Trustees’ determination, in order to maintain their eligibility.

A member also has the right to appeal non-medical issues relating to denial of their 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 may ask you to provide additional information, or appear for an evaluation before an independent medical specialist.

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.
Am I Required To Report To NYCERS Any Income I Earn While Collecting My Disability Retirement Benefit?

Yes. Once each year, you will be required to complete, and return to NYCERS, an Affidavit of Personal Service Income for Tier 3 or Tier 4 Disability Retirees disclosing your income during the preceding calendar year.

Are There Any Limitations On Income Earned While I Collect A Disability Retirement Benefit?

Most pensioners are subject to limits on the income they earn while collecting disability retirement benefits. The extent to which income is limited depends on the specific disability law the member retired under.

In addition to the limitations on your income, other rules may apply to your employment while you are disabled. Before accepting employment, you should consult with a NYCERS’ representative to determine whether you are subject to earnings limitations.

What Happens If I Am No Longer Disabled And Want To Return To Work?

Members retired by reason of disability for more than one year 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, every retiree receiving a disability retirement benefit from NYCERS 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 retirement benefits will 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 retirement benefit.

Note: You should 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?

Disability retirement benefits for Tier 3 and Tier 4 members are not subject to New York State and local income taxes. They are, however, subject to Federal income tax.

The only exceptions are Uniformed Correction Officers, Emergency Medical Service employees, Uniformed Sanitation employees, and NYC Deputy Sheriffs who receive a 3/4 accident disability retirement benefit, or line-of-duty disability retirement benefit, which is free of Federal income tax.

Are There Any Offsets To My Disability Retirement Benefits (i.e. Social Security & Workers’ Compensation)?

Offsets are applied to some disability retirement benefits but the rules vary according to your Tier, and the type of disability you retired on. Check with NYCERS’ Medical Unit staff for more information.

Who Administers My Health Insurance Coverage?

NYCERS does not administer health benefits.

Ask your agency’s personnel or human resources department about active employees’ health insurance. Questions regarding retiree health insurance, and deductions, should be directed to the following:

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

Can An Application For Disability Retirement Be Withdrawn?

If NYCERS’ Medical Board has not yet finalized its findings, you may withdraw your application for a disability retirement benefit, upon written request to NYCERS.
### Disability Retirement Tier 3 and Tier 4

<table>
<thead>
<tr>
<th>PLAN</th>
<th>DISABILITY ELIGIBILITY REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 4 with Tier 3 Rights (Non-Correction Officers)</td>
<td>Five or more years of Credited Service. You must be found disabled, and awarded Primary Social Security Disability Benefits by the Social Security Administration.</td>
</tr>
<tr>
<td>Tier 4</td>
<td>Ten or more years of Credited Service.</td>
</tr>
<tr>
<td>Basic Tier 3 Uniformed Correction Force</td>
<td>Five or more years of Credited Service. You must be found disabled and awarded Primary Social Security Benefits by the Social Security Administration.</td>
</tr>
<tr>
<td>Special Tier 3 Uniformed Correction Force</td>
<td>Ten or more years of Credited Service.</td>
</tr>
</tbody>
</table>

There are no minimum service requirements for Disability Retirement due to an accident.

**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.

### Disability Retirement Effective Date & Filing Requirements

<table>
<thead>
<tr>
<th>PLAN</th>
<th>EFFECTIVE DATE</th>
<th>FILING REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Tier 4 with Tier 3 Rights, and Tier 3 Uniformed Correction Force</td>
<td>Same as effective date of Social Security Disability Award date or Six months from the date the application is filed, if ineligible for Primary Social Security Disability Benefits, and NYCERS Medical Board determines you are disabled.</td>
<td>You or another person acting on your behalf or A committee or conservator duly appointed by a court of competent jurisdiction or The head of the agency where you are employed and must be filed while in active pay status or While on an authorized leave of absence without pay and • Leave was granted for medical reasons; • Has been in effect continuously since you were last paid on the payroll, and • Two years have not elapsed from the date you were being paid on the payroll</td>
</tr>
<tr>
<td>Tier 4</td>
<td>Later of: 30 days after the date the application is filed with NYCERS or Day after last day you were paid on your employer’s payroll.</td>
<td>You or another person acting on your behalf or A committee or conservator duly appointed by a court of competent jurisdiction or The head of the agency where you are employed and must be filed within three months after last date you were paid on your employer’s payroll or Within 12 months after receipt of notice that your employment was terminated, if you were on a medical leave of absence without pay prior to your termination.</td>
</tr>
<tr>
<td>Special Tier 3 Correction Force Plan</td>
<td>Later of: 30 days after the date the application is filed with NYCERS. or Day after last day you were paid on your employer’s payroll.</td>
<td>You or another person acting on your behalf or Committee or conservator duly appointed by court of competent jurisdiction or The head of the agency where you are employed and must be filed within three months after last date you were paid on your employer’s payroll or Within 12 months after receipt of notice that your employment was terminated if you were on a medical leave of absence without pay prior to your termination.</td>
</tr>
</tbody>
</table>
Various laws and NYCERS’ Rules govern post-retirement earnings limitations for disability retirees. This brochure details such limitations. Please refer to the section of this brochure applicable to your tier.

**TIERS 1 AND 2**

**LIMITS BEFORE ATTAINING SERVICE RETIREMENT AGE**

Section 13-171 of the NYC Administrative Code provides that a disability retiree may receive income from employment in the private sector or the public sector if he or she has not yet met the age requirement (service requirement for retirees of a special plan which permits retirement without regard to age) under his or her retirement plan. The amount a pensioner may earn is the difference between the maximum current salary of the next higher title from that which he or she retired, and the maximum pension portion of his or her retirement allowance.*

**LIMITS AFTER ATTAINING SERVICE RETIREMENT AGE**

Once a disability retiree attains the minimum age requirement (service requirement for retirees of a special plan which permits retirement without regard to age) for his or her retirement plan, Section 1117 of the NYC Charter governs post-retirement public employment. Section 1117 provides that a retiree’s pension must be suspended if his or her total pension and earned income from the City, State or a municipality within New York State exceeds $1,800 in any year.** NYC Transit retirees are not subject to this limitation. Income from Public Benefit Corporations or the private sector is exempt from the $1,800 limitation in the NYC Charter.

**TIERS 3, 4 AND 6**

Tier 3, 4 and 6 disability retirees are generally subject to post-retirement earnings limitations. The extent to which these limitations apply depends on the specific law under which you retired. The following table shows the limitations under each law. If you do not know the disability law you retired under, refer to your Retirement Resolution or data sheet which was given to you at retirement.

<table>
<thead>
<tr>
<th>NYS Retirement &amp; Social Security Law (RSSL) Section(s)</th>
<th>EARNINGS LIMITATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual Purpose Disability Statutes for Tier 4 and Tier 6 Members, and Tier 3 Uniformed Corrections (605 &amp; 507-a) Public &amp; ***Private employment anywhere</td>
<td>$31,800 for 2019 (will change annually based on the Consumer Price Index) Exceeding this earnings limitation will result in the suspension of your pension for 12 months</td>
</tr>
<tr>
<td>Accidental Disability for Tier 4 and Tier 6 Uniformed Sanitation (605-b)</td>
<td>Tiers 1 &amp; 2 safeguards apply (See Tiers 1 &amp; 2 section)</td>
</tr>
<tr>
<td>Line-of-Duty Disability for Tier 3 Uniformed Corrections (507-c) Line-of-Duty Disability for Tier 4 and Tier 6 Emergency Medical Technicians (607-b) Accidental Disability for Tier 4 and Tier 6 Deputy Sheriffs (605-c) Tier 3 General Members and 22-Year Plan [506 (Ordinary), 507 (Accidental)] Public employment within NYS only</td>
<td>$1,800 (including any pension earned) per Section 1117 of the NYC Charter</td>
</tr>
<tr>
<td>Line-of-Duty Disability for Tier 3 Uniformed Corrections (507-c) Line-of-Duty Disability for Tier 4 and Tier 6 Emergency Medical Technicians (607-b) Accidental Disability for Tier 4 and Tier 6 Deputy Sheriffs (605-c) Tier 3 General Members and 22-Year Plan [506 (Ordinary), 507 (Accidental)] ***Private employment anywhere &amp; Public employment outside of NYS</td>
<td>NO LIMITATION</td>
</tr>
<tr>
<td>TRANSIT RETIREE ONLY (Retired under RSSL §§ 506, 507, 605) Public &amp; ***Private employment anywhere</td>
<td>NO LIMITATION</td>
</tr>
</tbody>
</table>

*Exceeding earnings limitations under Section 13-171 will result in the suspension of your pension for the remainder of that calendar year.

**Since the pension and earned income are added together to compare to the $1,800 limit most pensioners will exceed this limit once they start working. The pension will remain suspended for as long as you continue to work.**

***Employment with a Public Benefit Corporation in NYS is considered Private Employment.
Mail Completed Forms to:
30-30 47th Avenue, 10th Fl
Long Island City, NY 11101

NYCERS WALK-IN and CALL CENTER Hours: Monday & Wednesday 8 am – 6 pm     Tuesday & Thursday 8 am – 5 pm     Friday 8 am – 3 pm

Authorization for Release of Information

Only use this form to authorize the New York City Employees’ Retirement System (NYCERS) to provide information and/or records to a third party on your behalf, upon request. If you have any questions, please contact NYCERS’ Call Center at 347-643-3000.

NOTE: If the address you provide on this form is different from your address on file with NYCERS, the new address will become your official address in NYCERS’ records.

Member Number  OR  Pension Number  Last 4 Digits of SSN  Phone Number

First Name  M.I.  Last Name

Address  Apt. Number

City  State  Zip Code

Union and Employer Authorization:

☐ Do not share my Medical and Non-Medical records with my union or employer.

Authorization for all other Entities:

I, __________________________________ , hereby authorize the New York City Employees’ Retirement System (NYCERS) to provide _____________________________________________  of  ___________________________________________________ Address:______________________________________________________ Daytime Phone: _______________________________

(thereinafter Third Party), with the following information regarding the NYCERS account referenced above (check all that apply):

☐ Any and all Non-Medical records.
☐ Only the specified Non-Medical records listed below:

☐ Any and all Medical records.
☐ Only the specified Medical records listed below:

I understand that NYCERS has no authority to control the future use or dissemination of any information released to the Third Party identified above. Therefore, I release NYCERS, the City of New York, and any officers, agents, or employees thereof, from any and all liability that may arise out of the Third Party’s possession and/or use of the information and/or records provided pursuant to this authorization. This authorization is effective on the date signed below, and will remain in effect until NYCERS’ receipt of a written, notarized revocation from the Member/Pensioner/Beneficiary.

Signature of Member/Pensioner/Beneficiary  Date

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.

Signature of Notary Public or Commissioner of Deeds  Official Title  Expiration Date of Commission

If you have an official seal, AFFIX IT