



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.

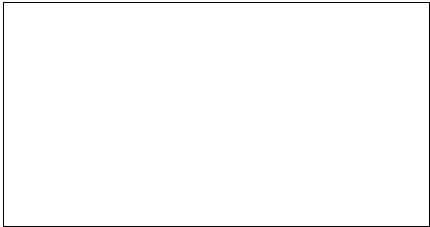
Please read carefully: It is your responsibility to:

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 4 Members**

This application is for Tier 4 members who wish to apply for Disability Retirement. Before you complete this application, be sure to read the TERMS section on page 4.

In addition to this application, you must also submit to NYCERS:

- Applicant's Report of Personal Disability (Form #605)
- General Authorization for Release of Medical Information (Form #608)
- Physician's Report of Disability (Form #606)
- NYCERS Questionnaire (Form #609)

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. Should you have any questions, please contact our Medical Unit at 347-643-3000.

Select a Benefit:

Please mark the disability sections that apply to you. You may be eligible to apply for more than one benefit.

I am applying for:

- Disability Retirement (RSSL §605)
- EMT ¾ Performance-of-Duty Disability (RSSL §607-b)
- Uniformed Sanitation ¾ Accidental Disability (RSSL§605-b)
- EMT Heart Bill (GML §207-q)
- Uniformed Sanitation Heart Bill (GML §207-r)
- Deputy Sheriffs ¾ Accidental Disability (RSSL §605-c)
- Disability Retirement under the World Trade Center Law (see WTC Fact Sheet for more information)

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

Member Number	Last 4 Digits of SSN	Daytime Phone Number	Date of Birth [MM/DD/YYYY]
		()	/ /
First Name	M.I.	Last Name	
Address			Apt. Number
City	State	Zip Code	
Agency	Title		

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).

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Member Number	Last 4 Digits of SSN

Select an Interim Option: This section allows you to select an Interim Option (temporary option). Selecting an Interim Option protects you and your beneficiary(ies) during the period between your retirement date and the date you make a final option selection. It enables you to leave some form of your pension payment to whomever you designate on page 3 of this application should you die before a final option selection is made and your pension is finalized. You may choose to be temporarily covered by one of the options listed below. **If you do not select an Interim Option and you die before your pension is finalized, it is assumed that you selected the Maximum Retirement Allowance and your pension will not continue upon your death.**

Option 1 -- 100% Joint-and-Survivor:
Option 1 is a reduced benefit that is payable to you for your lifetime. It guarantees that the same reduced benefit will continue to your surviving designated beneficiary for life. Payments cease upon the death of both you and your beneficiary.

Option 2 -- 75%/50%/25% Joint-and-Survivor:
Option 2 is a reduced benefit that is payable to you for your lifetime. It guarantees that a percentage of your retirement allowance will be payable to your designated beneficiary for his or her lifetime. Your beneficiary will receive 75% or less (in 25% increments) of the reduced benefit paid to you. All payments cease after the death of both you and your designated beneficiary.

Indicate Percentage: 75% 50% 25%

Option 3 -- Five-Year Certain:
Option 3 is a reduced benefit that is payable to you for your lifetime. If you die within five years from the date of retirement, the reduced benefit will continue to be paid to your Primary Beneficiary for the unexpired balance of the five-year period. If your Primary Beneficiary predeceases you, the payments due for the remainder of the five-year period are continued to your Contingent Beneficiary (if there is one) upon your death. If none exists, the balance is paid in a lump sum to your estate. Should your Primary Beneficiary die after having started to receive payments, the balance will be paid in a lump sum to your Contingent Beneficiary. If none exists, the lump-sum balance is paid to the estate of your Primary Beneficiary. Unlike Options 1 and 2, you may change your beneficiary(ies) with this option, but only within five years from the date of retirement.

Option 4 -- Ten-Year Certain:
Option 4 is a reduced benefit that is payable to you for your lifetime. If you die within ten years from the date of retirement, the reduced benefit will continue to be paid to your Primary Beneficiary for the unexpired balance of the ten-year period. If your Primary Beneficiary predeceases you, the payments due for the remainder of the ten-year period are continued to your Contingent Beneficiary (if there is one) upon your death. If none exists, the balance is paid in a lump sum to your estate. Should your Primary Beneficiary die after having started to receive payments, the balance will be paid in a lump sum to your Contingent Beneficiary. If none exists, the lump-sum balance is paid to the estate of your Primary Beneficiary. Just like Option 3, you may change your beneficiary(ies) with this option, but only within ten years from the date of retirement.

Option 5 -- 100% or 50% Joint-and-Survivor with Pop-Up:
Option 5 is a reduced benefit that is payable to you for your lifetime. Under this option, your designated beneficiary will receive the benefit payable under the 50% or 100% joint-and-survivor option (see Option 1 or Option 2). However, should your designated beneficiary predecease you, your retirement allowance will "pop up" to the Maximum Retirement Allowance for the remainder of your life. All payments cease upon your death.

Indicate Percentage 100% 50%

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Member Number	Last 4 Digits of SSN

Select a Beneficiary(ies)

Primary Beneficiary	First Name	M.I.	Last Name		
	Full Social Security Number	Date of Birth [MM/DD/YYYY]	Relationship	Daytime Phone Number	
		/ /		()	
	Address			Apt. Number	
City			State	Zip Code	

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

If you have chosen the Five-Year Certain Option or Ten-Year Certain Option, please also designate a Contingent Beneficiary below.

Should my Primary Beneficiary die before the five-year period or ten-year period expires, respectively, the Contingent Beneficiary whom I nominate is:

Contingent Beneficiary	First Name	M.I.	Last Name		
	Full Social Security Number	Date of Birth [MM/DD/YYYY]	Relationship	Daytime Phone Number	
		/ /		()	
	Address			Apt. Number	
City			State	Zip Code	

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

I, the undersigned, request to apply for Disability Retirement under the disability section(s) I marked on Page 1.

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.

If you have an official seal, affix it

Signature of Notary Public or Commissioner of Deeds _____

Official Title _____

Expiration Date of Commission _____

Sign this form and have it notarized, THIS PAGE



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TERMS

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 (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.

Uniformed Sanitation $\frac{3}{4}$ Accidental Disability (RSSL §605-b):

A Uniformed Sanitation member is eligible to apply for Accidental 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. Application must be made within two years after the occurrence of the accident.

Uniformed Sanitation Heart Bill (GML §207-r):

The Heart Bill provides a 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 Bill are entitled to an Accidental Disability Benefit. The presumption may be rebutted by competent medical evidence.

Filing Requirements for RSSL §§605-c, 607-b and GML §207-q

You must file this application while you are actually employed in the eligible titles (Deputy Sheriff, EMT).

Deputy Sheriffs $\frac{3}{4}$ Accidental 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 Accidental Disability Benefit.

EMT $\frac{3}{4}$ 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.

EMT Heart Bill (GML §207-q):

The Heart Bill provides a presumption that a disease of the heart was incurred in the performance of duty. EMTs who are approved for disability under the Heart Bill are entitled to a Performance-of-Duty Disability Benefit. The presumption may be rebutted by competent medical evidence.

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.

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.

Sign this form and have it notarized, Page 4



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)

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

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.

Subjective evidence:

Symptoms, Complaints, Etc.

Treatment and result:



--

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] / /

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.

Signature of Member	Date
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Questionnaire Applicants for Disability Retirement

This application is to accompany your application for Disability Retirement. Please be sure you read and understand the questions asked on this form before answering. Should you have any questions, please contact our Call Center at 347-643-3000.

Member Number	Last 4 Digits of SSN

First Name	M.I.	Last Name

This section must be completed by ALL members applying for Disability Retirement.

1. What is (are) the disabling condition(s) which is (are) the basis for your applying for disability retirement?

2. Check all relevant boxes that indicate your symptoms

<input type="checkbox"/> Pain	<input type="checkbox"/> Weakness	<input type="checkbox"/> Difficulty Walking
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Depression	<input type="checkbox"/> Other _____

3. When did symptoms begin? [MM/DD/YYYY]

/ /

4. Please list the name(s), address(es) and frequency of persons and/or institutions from whom you are receiving treatment.

5. Nature of treatment, including medications being taken.

6. Check boxes below to indicate tests performed: **(Bring a copy of ALL REPORTS, if possible.)**

<input type="checkbox"/> Blood and Urine	<input type="checkbox"/> X-Rays	<input type="checkbox"/> EMG (Electromyogram)
<input type="checkbox"/> EKG (Electrocardiogram)	<input type="checkbox"/> Myelogram	<input type="checkbox"/> CT scan
<input type="checkbox"/> Stress Test	<input type="checkbox"/> Pulmonary Function studies	<input type="checkbox"/> Pathology or Biopsy Reports
		<input type="checkbox"/> Other _____

7. Hospital admission(s): (Hospital Reports must be supplied to this office.)

(A) Name of hospital(s):

1). _____

2). _____



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]
 / / / / / /



Member Number	Last 4 Digits of SSN

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 _____	<input style="width: 100%; height: 20px; border: 1px solid black;" type="text" value="MM/DD/YYYY"/> / /
Name of Person or Institution _____	<input style="width: 100%; height: 20px; border: 1px solid black;" type="text" value="MM/DD/YYYY"/> / /
Name of Person or Institution _____	<input style="width: 100%; height: 20px; border: 1px solid black;" type="text" value="MM/DD/YYYY"/> / /



[Empty box for member information]

Member Number [] Last 4 Digits of SSN []

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

If Yes, give dates and description of injury _____ [MM/DD/YYYY] / /

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

If Yes, give dates and descriptions of injury _____ [MM/DD/YYYY] / /

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 lines]



Disability Retirement

Tier 3 and 4

July 2012

TIER MEMBERSHIP INFORMATION:

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.

WHAT IS DISABILITY RETIREMENT?

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 mischance, unexpected, out of the ordinary, and injurious in impact." Not every line of duty injury is determined to be an accident.

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 # 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.

The eligibility tables on the back page explain the filing requirements for disability retirement.

Disability Retirement Tier 3 and 4 - #922 - Page 1

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:

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, 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, Emer-

gency 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

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

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

PLAN	EFFECTIVE DATE	FILING REQUIREMENTS
Basic Tier 4 with Tier 3 Rights, and Tier 3 Uniformed Correction Force	<p style="text-align: center;">Same as effective date of Social Security Disability Award date</p> <p style="text-align: center;">or</p> <p>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.</p>	<p>You or another person acting on your behalf</p> <p style="text-align: center;">or</p> <p style="text-align: center;">A committee or conservator duly appointed by a court of competent jurisdiction</p> <p style="text-align: center;">or</p> <p>The head of the agency where you are employed and must be filed</p> <p style="text-align: center;">While in active pay status</p> <p style="text-align: center;">or</p> <p>While on an authorized leave of absence without pay and</p> <ul style="list-style-type: none"> • 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
Tier 4	<p style="text-align: center;">Later of:</p> <p>30 days after the date the application is filed with NYCERS</p> <p style="text-align: center;">or</p> <p>Day after last day you were paid on your employer's payroll.</p>	<p>You or another person acting on your behalf</p> <p style="text-align: center;">or</p> <p style="text-align: center;">A committee or conservator duly appointed by a court of competent jurisdiction</p> <p style="text-align: center;">or</p> <p>The head of the agency where you are employed and must be filed</p> <p>Within three months after last date you were paid on your employer's payroll</p> <p style="text-align: center;">or</p> <p>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.</p>
Special Tier 3 Correction Force Plan	<p style="text-align: center;">Later of:</p> <p>30 days after the date the application is filed with NYCERS.</p> <p style="text-align: center;">or</p> <p>Day after last day you were paid on your employer's payroll.</p>	<p>You or another person acting on your behalf</p> <p style="text-align: center;">or</p> <p style="text-align: center;">Committee or conservator duly appointed by court of competent jurisdiction</p> <p style="text-align: center;">or</p> <p>The head of the agency where you are employed and must be filed</p> <p>Within three months after last date you were paid on your employer's payroll</p> <p style="text-align: center;">or</p> <p>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.</p>

