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
Tier 6 63/10 and Special Plan Members

This application is for Tier 6 63/10 and Special Plan members who are applying 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 Medical Board):

- 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)
☐ EMT Heart Law (GML §207-q)
☐ World Trade Center (WTC) Disability Retirement

☐ Deputy Sheriffs ¼ Accident Disability (RSSL §605-c)
☐ EMT ¼ Performance-of-Duty Disability (RSSL §607-b)

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

Member Information:
Member Number
Last 4 Digits of SSN
Phone Number
Date of Birth [mm/dd/yyyy]

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: You may not name your Estate for the Joint-and-Survivor Option. An Estate can be named as a contingent beneficiary for the Ten-Year Certain 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.

☐ 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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☐ 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...
- 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 in a lump-sum to your contingent beneficiary. If none exists, the lump-sum balance is paid to the estate of the primary beneficiary. You may nominate both a primary and contingent beneficiary(ies) under this option.

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

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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.)

**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.**

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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.)

**Space for an additional contingent beneficiary on next page.**
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 Terms pages for details.)  Share of Benefit %

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.)

☐ 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 #624 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.

Terms

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.

You must file this application:

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.

Deputy Sheriffs ¼ 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.
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.**

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.

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.**

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

**Workers’ Compensation Payments Offset**
Disability Retirement benefits under RSSL §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.

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

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Percentage %

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

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

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.

Signature of Member

Date

Witnessed by (1):

Witnessed by (2):

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)

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

State of __________  County of __________ On this __________ day of __________ 2 0 ____, 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

NYCERS USE ONLY

F501
Applicant's Report of Personal Disability

Please return with member's application for disability retirement.

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

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
To NYCERS' Medical Board:

This is to certify that

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)

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

**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

________________________  __________________________
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, consults, 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 ___________________________ 

Initials ___________________________ Name of individual health care provider 

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

(Attorney/Firm Name or Governmental Agency Name) 

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. 

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

Member Number  Last 4 Digits of SSN  Phone Number  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 ________

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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month</td>
<td>Year</td>
<td>Month</td>
<td>Year</td>
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<td>3.</td>
<td>______ /</td>
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<td>4.</td>
<td>______ /</td>
<td>______</td>
<td>______ / ______</td>
<td>______ /</td>
<td>______ /</td>
</tr>
</tbody>
</table>

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>
</thead>
<tbody>
<tr>
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<td>Year</td>
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<td>______ / ______</td>
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</tr>
</tbody>
</table>
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>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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>
</tr>
</thead>
<tbody>
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</tbody>
</table>

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
- [ ] Pulmonary Function studies
- [ ] EMG (Electromyogram)
- [ ] CT scan
- [ ] Pathology or Biopsy Reports
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>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
<td>□ Yes     □ No</td>
</tr>
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<td>If Yes, provide date:</td>
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<td>If Yes, provide date:</td>
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<td>□ Yes     □ No</td>
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<td>If Yes, provide date:</td>
</tr>
</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? ____________________________________________________
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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

31. Have you had any accidents or injuries off the job?

☐ Yes   ☐ No

If Yes, give dates and description of injury:

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

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

R08/19
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>$31,100 for 2018 (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 RETIREES 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.
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.

<table>
<thead>
<tr>
<th>Member Number</th>
<th>OR</th>
<th>Pension Number</th>
<th>Last 4 Digits of SSN</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

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 ___________________________________________________ to ____________________________ (hereinafter 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:

[Signature of Member/Pensioner/Beneficiary]

[Date]

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

State of [State]  County of [County]  On this [Day] of [Month] 20[Year] , personally appeared before me the above named, [Name], 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