



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.

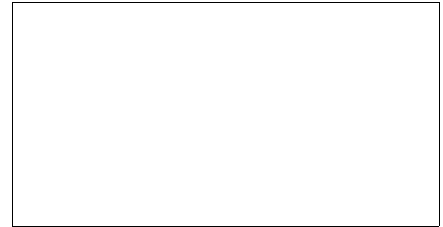
Please read carefully: It is your responsibility to:

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.



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



**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 Disability Retirement. Complete this form in its entirety, sign it, have it notarized, and send it to NYCERS at the mailing address above. If you wish to file this form in person, visit our Customer Service Center on the Mezzanine level of 340 Jay Street in downtown Brooklyn. If you have any questions regarding this form, please contact our Call Center at (347) 643-3000. **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.**

Withdrawal of Application: Provided that NYCERS' Medical Board has not yet finalized its findings, you may withdraw your application for disability retirement upon written request to NYCERS. You must also complete and submit Form #619 to NYCERS. **You may not withdraw an application filed by your agency on your behalf.**

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.

If you are approved for Disability Retirement, no advance (partial) pension payment will be sent to you until NYCERS has acceptable proof of your birthdate on file.

In addition to this application, you must also submit (to NYCERS' Medical Board):

- 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)

Select a Benefit:

I am applying for (check all that apply):

- Disability Retirement (RSSL §605)
- EMT Heart Bill (GML §207-q)
- EMT ¾ Performance-of-Duty Disability (RSSL §607-b)
- Deputy Sheriffs ¾ Accidental Disability (RSSL §605-c)

List your Disabling Conditions:

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

Member Number	Last 4 Digits of SSN	Home Phone Number ()	Work Phone Number ()
First Name		M.I.	Last Name
Address			Apt. Number
City		State	Zip Code
Title			
Agency			

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.** If you wish to select an option other than the two provided on this form, please contact our Call Center at (347) 643-3000.



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

Member Number	Last 4 Digits of SSN

Please read the descriptions below before choosing only one temporary option. If you choose the Maximum Retirement Allowance, do not name a beneficiary. Use your beneficiary's given name (Mary Smith, not Mrs. John Smith). Note: You may not name your Estate for either the Joint-and-Survivor or the Ten-Year Certain benefit.

- **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 one contingent beneficiary, and birthdate evidence for your beneficiary is not required.

CHOOSE ONLY ONE OPTION:

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.

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

Joint-and-Survivor Beneficiary	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 submit Form #137. If Form #137 is not submitted, NYCERS requires Letters of Guardianship for the Estate of the minor in order to pay a benefit to the minor.

--OR--

Ten-Year Certain

This temporary option provides that a benefit will be paid for 10 years if you die during the Interim Period. The benefit is calculated as if you had elected the Ten-Year Certain Option as your permanent option. Unlike a Joint-and-Survivor Option, the benefit payable under the Ten-Year Certain Option is not based on life expectancies, but rather on a defined period of time. Under this option, you receive a reduced pension (a pension lower than the Maximum Retirement Allowance) because the same amount continues for the remainder of the 10-year period upon your death. In this case, the benefit payable to your primary beneficiary is the same reduced pension you would have received during your lifetime. 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.



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

--

Member Number	Last 4 Digits of SSN

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

Ten-Year Certain Primary Beneficiary

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 submit Form #137. If Form #137 is not submitted, NYCERS requires Letters of Guardianship for the Estate of the minor in order to pay a benefit to the minor.

Ten-Year Certain Contingent Beneficiary

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 submit Form #137. If Form #137 is not submitted, NYCERS requires Letters of Guardianship for the Estate of the minor in order to pay a benefit to the minor.

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).



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

Member Number	Last 4 Digits of SSN

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 _____

TERMS

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.

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 ¾ 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. **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.**

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. **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.



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



Empty rectangular box for stamp or signature.

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.

- Checkboxes for understanding of medical records use, re-disclosure, HIV/AIDS information, and authorization of disclosure.

Signature of Member, Date



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 _____ / /

Name of Person or Institution _____ / /

Name of Person or Institution _____ / /



Empty rectangular box for member information.

Member Number

Last 4 Digits of SSN

Input fields for Member Number and 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

[MM/DD/YYYY]

If Yes, give dates and description of injury _____

Date input field: / /

Date input field: / /

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

[MM/DD/YYYY]

If Yes, give dates and descriptions of injury _____

Date input field: / /

Date input field: / /

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

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

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

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

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

If Yes, describe injury/disorder and treatment.

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

Do you drink occasionally? Yes No

If yes, how often? _____

How much? _____

35. Do you take any medications daily? Yes No

If Yes, What? _____

36. Do you use any recreational drugs? Yes No

If Yes, What and how often? _____

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

Are you receiving Workers' Compensation payments? Yes No

38. If Yes, how much bi-weekly? _____

Signature of Member

Date

Signature and Date input fields.