

**APPLICATION FOR DISABILITY RETIREMENT**

(Please complete all pages. If more space is required, attach additional sheets of paper. Print in ink.)

Date: _____

Social Security No.: _____		
Name: _____		
(First)	(Middle)	(Last)
Other names used during County employment: _____		
Address: _____		
(Street, Apt. No.)		

(City)	(State/Prov.)	(ZIP Code)
Home Phone No.: _____		Work Phone No.: _____
Cell Phone No.: _____		Fax No.: _____
Age: _____	Sex: _____	Birth Date: _____
Driver's License No.: _____		
Currently married or registered as a domestic partner? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, Date of Marriage/Registration: _____		
Spouse's/Domestic Partner's Name: _____		

Names and birth dates of children under 18 years of age:	
Name	Date of Birth
_____	_____
_____	_____
_____	_____

Position for which permanently incapacitated: _____	
Item No.: _____	Employee No.: _____
Department No.: _____	
Department Name: _____	Location: _____
Years of Service: _____	Last Date at Work: _____





I hereby apply for:

- Service-connected Disability Retirement
- Nonservice-connected Disability Retirement
- Supplemental Disability Retirement

I am willing to accept another position with the County which would not result in a loss of income to me and which I would be able to perform.

- Yes
- No

Service-connected salary supplement

Government Code Section 31725.65 allows retired members with service-connected disabilities to return to work, through a reemployment plan, in a new position they are capable of performing. Should the member opt to return to work in a lower-paying County position, LACERA will pay the member a supplemental allowance totaling the difference between the new, lesser-paying position and the previous higher-paying position. **Applies only to those members who were incapacitated for the performance of their duties on or after January 1, 2004, and who are eligible to retire for service-connected disability.***

Nonservice-connected salary supplement

Government Code Section 31725.5 allows retired members with nonservice-connected disabilities to return to work, through a reemployment plan, in a new position they are capable of performing. Should the member opt to return to work in a lower-paying County position, LACERA will pay the member a supplemental allowance totaling the difference between the new, lesser-paying position and the previous higher-paying position. **Applies to members eligible to retire for nonservice-connected disability.**

NOTE: If the Board of Retirement finds you are permanently incapacitated but the disability is not work-related, the Board may grant a nonservice-connected disability retirement. You **may appeal** that decision. **However, the Board's finding of disability will not be binding if appealed.**

While awaiting a decision on a Disability Retirement application, you may be eligible for a Service Retirement allowance.

General:

- Age 50 with 10 or more years of County (or combined County and reciprocal system) service credit
- At any age with 30 years of County (or combined County and reciprocal system) service credit
- Age 70 regardless of years of service credit

Safety:

- Age 50 with 10 or more years of County (or combined County and reciprocal system) service credit
- At any age with 20 years of County (or combined County and reciprocal system) service credit

I understand these eligibility requirements for the Service Retirement allowance and wish to apply. Yes No

If Yes, please provide me an estimate for retirement effective _____ (date).

NOTE: To apply for a service retirement, you may also call a LACERA Retirement Benefits Specialist, or complete the Request for Estimate form found on the Brochures & Forms page of lacera.com, and mail it to LACERA.

*Government Code 31725.6 applies to members who were incapacitated for the performance of their duties prior to January 1, 2004.



Current employment status with County (check all that apply):

- Working _____ hours per week.
- Sick leave with compensation. Approximate date leave ends: _____
- Industrial leave with compensation. Approximate date leave ends: _____
- Resigned or terminated from County service. Effective date: _____
- Receiving or have received Long-Term Disability (LTD) benefits administered by the County of Los Angeles Third Party Administrator.

What period(s) did you receive LTD? _____

1. Describe specifically the injury or illness causing you to be permanently disabled from performing your usual duties, including the body parts that are involved:

2. What date were you injured or first noticed you were ill? _____

3. Where did the injury or illness occur? _____

4. How did the injury occur, or what caused the onset of the illness?
(Please answer completely. Add additional page if necessary.)

5. Please list all witnesses to your job-related injuries or illness. Give names, work locations, phone numbers, and addresses of the witnesses.



6. Describe **actual** duties performed at the time your disability arose. (Attach County Class Specification. Class Specs are available from your Department or online at dhr.lacounty.info.)

7. State in detail the **usual** duties you **cannot** perform because of your disability.

8. (a) Are you claiming your job or job environment has aggravated or accelerated a preexisting injury or illness? **Yes** **No** **If Yes:**

(b) What is the nature of the **preexisting injury or illness**?

(c) Give the date of the original occurrence of the injury or onset of the illness.

9. (a) Have you ever received treatment for a similar injury or illness?

Yes **No** **If Yes:**

(b) Give the dates of treatment. _____

10. Are you presently self-employed or employed by anyone other than the County?

Yes **No** **If Yes:**

List employer's name, address, telephone number, as well as your job duties and hours.



11. **List all employers** (including other County departments) for whom you have worked in the last 10 years. Include addresses, telephone numbers, and periods of employment.

12. (a) List the names, addresses, and telephone numbers of all doctors or other service providers consulted for **your present injury or illness** and similar injuries or illnesses in the past. Include approximate dates, if known. Please list the dates of any future appointments related to your injury or illness. **(Add additional page if necessary.)**

(b) If you have been treated at Kaiser (S.C.P.M.G.), list the location and address of the facility. **Please include Kaiser Medical Record No.**

13. Have you ever received disability benefits, Workers' Compensation awards, disability pensions, or any other compensation for this or another injury or illness through the County or previous employer?

Yes **No** **If Yes, give details:**

14. Include any information you wish the Board of Retirement to consider in determining your disability.



15. Please list the name, address, and telephone number of your last supervisor.

Name: _____

Work Location: _____

Work Address: _____

Phone No: _____

If this individual supervised you for less than one year, list the name and telephone number of your prior supervisor.

Name: _____

Work Location: _____

Work Address: _____

Phone No: _____

16. (a) Generally, a disability retirement, once granted, becomes effective on the day the application is filed, or the day following the last day of regular compensation, whichever is later.* However, you may be entitled to have your disability retirement begin earlier if you delayed in filing your application and that delay was due to administrative oversight or the inability to determine your disability was permanent.

- If you are still receiving regular compensation, check this box and proceed to number 17.*
- Check this box if you are applying to have your disability allowance become effective earlier than the date this application is filed. Check the reason for this requested adjustment:
 - Administrative oversight
 - At the time I left work, the permanence of my disability could not be determined

*"Regular compensation" includes sick and vacation pay, and for purposes of this determination, Labor Code section 4850 pay. It does not include long-term disability (LTD) benefits.

WARNING: Failure to complete this section will constitute the waiver of the right to apply for an earlier effective date unless (1) you amend your application prior to the date you are referred to a LACERA-appointed physician for an examination, or (2) you amend this application at a later date by showing good cause for an amendment in accordance with Article VIII, Section 2(c) of the Bylaws of the Board of Retirement.



17. Have you retained an attorney to represent you in this disability retirement application process?

Yes No **If Yes:**

Attorney's Name: _____

Firm Name: _____

Address: _____

Phone No: _____

Note: The disability retirement application process is a separate matter from Workers' Compensation. Therefore, your Workers' Compensation attorney may not represent you. If you wish to have legal representation, you must arrange for it.

I declare, under penalty of perjury, that to the best of my knowledge the foregoing is true and correct.

Executed on _____ in _____, California.
(Date) (City)

Applicant's Signature*

Title*

Phone No.*

*If there is a Power of Attorney or guardianship for the employee, please attach a copy.



DISABILITY APPLICANT-MISSED MEDICAL APPOINTMENT

As provided in California Government Code Section 31723, upon determination that a medical examination is necessary, LACERA may order such an examination to determine the existence of the disability. At LACERA's expense, a medical appointment will be scheduled with a physician selected by LACERA. You will be notified by letter of the selected physician's name, address, telephone number, and the day and time of the appointment. Should you fail to keep this appointment without 48 hours advance notice to both the disability retirement section and the physician, you will be billed the physician's charges.

I understand it is my duty to contact the Disability Retirement Services Division of LACERA and the selected physician if I am unable to keep the medical appointment so ordered. If I fail to do so, the cost of the missed medical appointment is my responsibility.

Applicant's Signature: _____

Date: _____

