

APPLICATION FOR DISABILITY RETIREMENT

(Please complete all pages. If more space is required, attach additional sheets of paper. Type or 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.: _____		
Married or registered as a domestic partner at present? Yes <input type="checkbox"/> No <input type="checkbox"/>		
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: _____	
Years of Service: _____	Last Date at Work: _____





I hereby apply for:

Service-Connected or **Nonservice-connected disability retirement**

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.**

Please check one:

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 §31725.6 allows retired members with service-connected disabilities to return to work through a rehabilitation program via which they assume a new position they are capable of performing. Concurrence of the member in the plan is required. The disability retirement benefit is the difference between the new, lesser paying position and the higher paying position. **Applies only to those members who were incapacitated for the performance of their duties prior to January 1, 2004, and who are eligible to retire for service-connected disability.**

Service-connected salary supplement

Government Code §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. Concurrence of the member in the plan is required. The disability retirement benefit is the difference between the new, lesser paying position and the 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 §31725.5 allows retired members with service-connected disabilities to return to work, through a reemployment plan, in a new position they are capable of performing. This benefit is a voluntary one on the part of the applicant. The disability retirement benefit is the difference between the new, lesser paying position and the higher paying position. **Applies to members eligible to retire for nonservice-connected disability.**

Yes No **While awaiting a decision on a Disability Retirement application, you may be eligible for a Service Retirement allowance.** The eligibility requirements for a Service Retirement allowance are having at least 10 years of County service credit and being at least age 50. **I understand these eligibility requirements for the Service Retirement allowance and wish to apply.**

Please provide me an estimate for retirement effective _____ (date). **NOTE:** You may also call a LACERA Retirement Benefits Specialist to apply, or complete the Request for Estimate form found on the Brochures & Forms page of the web site at www.lacera.com, and mail it to LACERA.



Current employment status with County (check all items which 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) administered by Sedgwick CMS Company.*

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.)**

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

*Formerly called Voluntary Plan Administrators (VPA)



6. Describe **actual duties performed** at the time your disability arose. (Attach Class Specification.)

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 for your injury or illness.

(b) If you have been treated at Kaiser (S.C.P.M.G.), please list the location and address of the facility.

13. Have you ever received disability benefits, awards, pensions, or medical 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 and telephone number of your last supervisor.

Name: _____; Phone No: _____. If this individual supervised you for less than one year, please list the name and telephone number of your prior supervisor. Name: _____; 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 that your disability was permanent.

- If you are still receiving compensation, please check here and proceed to number 17.
- Please check here if you are applying to have your disability retirement allowance become effective earlier than the date this application is filed and proceed to 16 (b).

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 in accordance with Article VIII, Section 2(k) of the Bylaws of the Board of Retirement by showing good cause for an amendment.

(b) Please indicate the facts you rely on to show the filing of your application was delayed due to administrative oversight or by the inability to determine the permanency of your disability until after the date following the last day for which you received your regular compensation:



17. Your Workers' Compensation attorney will not represent you in this application process for disability retirement unless you specifically request representation.

Will an attorney represent you in this application process? **Yes** **No** **If yes:**

Include attorney's name, address, and telephone number.

Executed on _____ in _____, California.
(Date)

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

Employee Signature

Authorized Employer Signature*

Title*

Phone No.*

*Required only when department files on behalf of employee.



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 that it is my duty to contact the Disability Retirement Section 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.

Employee Signature

Date