MSRS
Minnesota State Retirement System

APPLICATION FOR MSRS DISABILITY

STATE PATROL PLAN

Disability Means: (a) a condition which renders a covered employee physically or mentally unfit to perform the duties of the position as a direct result of an injury, sickness, or other disability incurred in or arising out of an act of duty; or (b) a condition which renders a covered employee unfit to perform the duties of the position because of sickness or injury occurring while not engaged in covered employment.

Data Privacy: The information you supply on this form is for internal use by the Minnesota State Retirement System (MSRS) only. You are not legally required to provide this information, but we may not be able to pay your benefit without it. No private data will be shared with any unauthorized person or organization without your informed written consent.

Name: Social Security # Department:

Address: Number Street City State ZIP

( )
Home Phone# Date of birth(DOB) Spouse's Name Spouses DOB Last working day

1. Explain your disability

2. List physicians or clinics familiar with your condition

Name Address (Street, City, State, ZIP) Date of last visit

3. List surgeries or hospitalization required by disability

Surgery/hospital Surgeon Address (Street, Cut, State, ZIP) Date of treatment

4. Current job title _____

5. Is your injury or illness a direct result of your employment? ❒Yes ❒No

6. If yes, was a written report made to your employer? ❒Yes ❒No

7. Have you filed or intend to file for Workers' Compensation? ❒Yes ❒No

8. Are you collecting Workers' Compensation ❒Yes ❒No

9. Are you, or do you plan on, working an other than state police position? ❒Yes ❒No

10. If yes, enter the type of work and approximate monthly income _____

11. Do you want an optional disability? ❒Yes ❒No

Complete the next section only if you want an optional disability.

An optional disability provides a lower payment now and payment to your named survivor upon your death. The 100%, 75%, and 50% options include a bounce-back feature. This means that if your survivor dies first, your benefit would "bounce-back" to the Single-Life amount.

If you select an option, attach a copy of your survivor's birth record.

- ❒ 100% option: Your survivor receives 100% of your payment after you die.
- ❒ 75% option: Your survivor receives 75% of your payment after you die.
- ❒ 50% option: Your survivor receives half of your payment after you die.

Survivor's full name (including maiden name): _____

Survivor's relationship to you: _____ Survivor's SSN _____

12. Signatures and Notary Witness

I hereby acknowledge the benefit selection made by my spouse.

_____

Signature of spouse Date

I authorize and direct any physician, hospital, agency or other organization to disclose all information that it may possess to verify this disability claim. I affirm that the statements in this application are complete and true.

_____

Signature of member Date

Witness by notary is required. Subscribed and sworn to before me NOTARIAL STAMP OR SEAL

this _____ day of _____, 20 _____

_____

Notary signature

Return this completed application to Minnesota State Retirement System (MSRS), 60 Empire Drive, Suite 300, St Paul, MN 55103-3000.

If you need help completing this application, visit or write to MSRS or call our main office at (651) 296-2761 or (800) 657-5757. This application can be made available in an alternative format such as: large print, Braille, or cassette tape. Teletypewriter and telecommunications-device-for-the-deaf (TDD) call the Minnesota Relay Service at (800) 627-3529 and ask to be connected to (651) 296-2761.