MSRS Minnesota State Retirement System
Your Foundation for Retirement

MSRS Disability Benefit Packet
Correctional Retirement Plan

The information you supply on this application is for use by the Minnesota State Retirement System (MSRS), and its medical advisors, including Managed Medical Review Organization (MMro). You are not legally required to provide this information, but we may not be able to process your claim without it.

Important note:

- **Submit this application after you are no longer physically at work.**
- **We must receive your application for a disability benefit within 18 months of the date you terminate state employment.**

Definitions

Disability definition
A Correctional Retirement Plan disability is defined as an occupational disability, physical or psychological, that prevents a member of the Correctional Retirement Plan from performing the normal duties required by their position **for at least one year.**

Duty-related disability
An injury must be incurred or a disease must arise while performing normal or less frequent duties that **present inherent danger** and are specific to a position covered by the plan.

Regular disability
An injury may be incurred or a disease may arise from activity while not at work, or while at work and performing normal or less frequent duties that **do not present inherent danger** and are specific to a position covered by the plan.

What's next

- **Forms**
  Complete and return the required forms to MSRS (see checklist to the right).
- **Medical advisor**
  Your information will be forwarded to our medical advisor for review.
- **Approval or denial**
  We will notify you by mail of the medical advisor's recommendation in about 45 to 75 days.

  If your disability claim is approved, you will receive your first payment four to six weeks after the last day you are paid salary, or, up to 180 days prior to receipt of your application, whichever is later.

  If your disability claim is denied, you may appeal the decision in writing within 60 days of receiving notification.
- **Post approval**
  After approval of a disability benefit, your disability status may be recertified by a physician once a year for the first five years and once every three years thereafter until full retirement age.

Checklist

The following forms and documents are required to process your disability application.

- ❒ *Application for MSRS Disability Benefit*
- ❒ *Employer Certification* form (to be completed by your employing agency/department)
- ❒ *Physician's Statement* (must submit two)
- ❒ *Withholding Certificate* (*W-4P*)
- ❒ *Direct Deposit Agreement* form
- ❒ *Public Safety Authorization for Insurance Premium Deduction* form (optional)
- ❒ Photocopy of Birth Record(s)
- ❒ Certified copy of Divoce Decree(s) and/a Domestic Relations Order (DRO), if applicable
- ❒ Photocopy of Marriage Certificate

If you have questions or need assistance, please call 651-296-2761 or toll free 1-800-657-5757 and ask to speak to a disability specialist.

Remove this page and keep for your records. Please return pages 2 - 6 to MSRS.

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1. Information about you

Last name	First name	MI	MSRS ID or SSN

Mailing address	Date of birth

City	State	Zip code

Home phone	Alternate phone

Marital status ❒ Single ❒ Married ❒ Divorced *Please attach a copy of your divorce decree if not previously submitted.*

Spouse's name	Spouse's date of birth

Employing agency/department	Last day physically on the job

2. Medical information

1. Explain your disabling condition:

❒ See attachment for additional explanation of disabling condition

2. Are you confined to your home, bedridden, or using a wheelchair? ❒ Yes ❒ No

If yes, since when: ____/____/____
Month Day Year

3. Did or does your condition require surgery? ❒ Yes ❒ No

If yes, date of surgery: ____/____/____
Month Day Year

Type of procedure: _____

Facility or medical provider: _____

4. Have you been hospitalized because of your disabling condition? ❒ Yes ❒ No

If yes, date(s) hospitalized: From ____/____/____ To ____/____/____
Month Day Year Month Day Year

5. List the physicians most familiar with your disabling condition:

Doctor or Clinic	Specialty	Dates of Medical Appointment	
		First	Most Recent

3. Other benefits

6. Are you receiving Workers' Compensation payments? ❒ Yes ❒ No
7. Is your injury or illness a direct result of your employment? ❒ Yes ❒ No

   If yes, was a *First Report of Injury* filed? (please attach) ❒ Yes ❒ No
8. Do you have allowable or refunded service covered by another Minnesota retirement fund, e.g. Public Employees Retirement Association (PERA) or Teachers Retirement Association (TRA), etc? ❒ Yes ❒ No

   If yes, list the Minnesota retirement fund(s): _____

4. Benefit options

The Single-Life benefit provides the highest benefit. A Joint and Survivor benefit provides for a lower payment now and payment to your named survivor after your death. The 100 percent, 75 percent, and 50 percent options include a bounce-back feature. This means that if your survivor predeceases you, your benefit would increase to the Single-Life amount.

Minnesota law requires that your spouse receive at least a 50 percent option, unless your spouse waives their right to this benefit.

Please check one option.

❒ **Single-Life benefit** - This benefit only covers you. Your benefit ends upon your death.

❒ **100 Percent Joint and Survivor benefit** - Your survivor would receive a monthly benefit amount equal to your benefit after your death. If your survivor is not your spouse, your survivor cannot be more than 10 years younger than you for this option.

❒ **75 Percent Joint and Survivor benefit** - Your survivor would receive 75 percent of your monthly benefit after your death. If your survivor is not your spouse, your survivor cannot be more than 19 years younger than you for this option.

❒ **50 Percent Joint and Survivor benefit** - Your survivor would receive one-half of your monthly benefit after your death.

❒ **Life Income, 15-Year Certain benefit** - You receive a reduced payment for life. If you die before you have collected for 15 years, your survivor would continue to receive the benefit for the balance of the 15 years.

You will receive an authorization letter confirming your benefit about the time of your first payment. You may change your benefit option up to 30 days from the date of the letter.

5. Joint and survivor information

Complete this section if you did not select the Single-Life benefit.

Name	SSN	Relationship to member

If you selected the 100 percent, 75 percent or 50 percent option, attach a photocopy of your survivor's birth record.

6. Spouse's signature

I am the spouse of this member. I am aware of the survivor options available to protect me. I have read, understand and agree to the benefit selected by my spouse.

Spouse's signature _____ Date _____

Subscribed before me this ____ day of _____, 20 _____ Notary Stamp

County of _____

State of _____

Notary public's signature _____

7. Applicant's signature

I am applying for my disability benefit from MSRS. I verify all statements are true and complete.

Applicant's signature _____ Date _____

Subscribed before me this ____ day of _____ , 20 _____ Notary Stamp

County of _____

State of _____

Notary public's signature _____

Please sign the HIPAA Disclosure on the next page

Minnesota State Retirement System
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Participant's Authorization and Acknowledgment

1. HIPAA Disclosure

I, _____, authorize _____
Your Name *Name of Doctor or Clinic*

to release medical information to the Minnesota State Retirement System (MSRS) and its medical advisors, including Managed Medical Review Organization (MMRO).

> *Medical information with respect to any physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, and mental health.*

I understand the information obtained will be included as part of the proof of claim and will be used to determine eligibility for benefits, return of employment opportunities, and assessment of ongoing treatment. Any information obtained will not be released to any person or organization except MSRS and its medical advisors.

I agree that a photographic copy of this Authorization shall be as valid as the original.

I understand that I may request a copy of this Authorization. This Authorization shall become effective on the date appearing below my signature.

I understand I have the right to revoke this Authorization at any time by notifying MSRS in writing.

I understand that revoking this Authorization may impair the necessary processing of my application.

I, the undersigned, state that the information I provided in my disability application is complete and true to the best of my knowledge and belief. I understand that, by applying for a disability benefit, I authorize my physician(s) to provide MSRS and their medical advisors, including MMRO, with my medical information.

Participant's name (please print): _____

Participants date of birth: _____

Participant's signature: _____

Date: _____

Mail the completed form to:

60 Empire Drive, Suite 300
St. Paul, MN 55103-3000

Toll-free: 1-800-657-5757
Fax: 1-888-529-1832

Teletypewriter users and telecommunications-device-for-the-deaf (TDD) users call the Minnesota Relay Service at 1-800-627-3529 and ask to be connected to MSRS at 651-296-2761.

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