



To be completed by your employing agency/department

The employee listed below has applied for a disability benefit from the Minnesota State Retirement System (MSRS).

**Please complete this form and return to MSRS.**

### 1. Employee information

Last name	First name	MI
Applicant's job title		MSRS ID

### 2. Employment Information

1. Has the employee terminated employment?  Yes  No  
 If yes, please provide termination date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

2. Is the employee on a leave of absence?  Yes  No  
 Unpaid leave  Paid leave; payment start date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year



3. Is the employee receiving workers' compensation payments?  Yes  No

4. Is the employee able to perform their current job duties?  Yes  No

**Required:** Please include a copy of employee's current position description

### 3. Required signatures

Authorized signature	Print name		
Title	Department		
Daytime phone number	Alternate phone number	Date	
Mailing address	City	State	Zip code

<p>If you have questions or need assistance, please call MSRS and ask to speak with a Disability Specialist</p> <p style="text-align: center;">651.296.2761 or 1.800.657.5757</p>	<p>Mail or fax the completed form to:</p> <p> MSRS 60 Empire Drive, Suite 300 St. Paul, MN 55103-3000</p> <p> Fax: 651.297.5238</p>
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