MSRS Minnesota State Retirement System

Application for Disability Benefits
General Employees 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 application without it.

Important note:

- Submit all required forms after you are no longer physically at work. **You do not need to terminate state employment in order to apply.**
- We must receive your application for a disability benefit within 18 months after the date you terminate state employment.

Definition of Total and Permanent Disability

State law defines total and permanent disability as the inability to engage in any substantial or gainful activity as a result of an existing, medically proven physical or mental impairment that is expected to continue for at least one year.

Required items to process your request:

The following four forms are required to process your disability application.

Incomplete forms may be returned to you and will delay the processing of your application for disability benefits.

- ☐ Application for Disability Benefit - Completed by you
- ☐ Employer Certification form and Position Description
  Completed by your employing agency or department.
- ☐ Medical Statement (2 required)
  Completed by two different medical professionals. At least one of the forms requires completion by a medical doctor.

Deadline to submit forms

If you have terminated employment, all four forms must be received by MSRS in good order within 18 months of your termination date. Forms received after the deadline will not be accepted and will result in a denied application for a disability benefit.

Additional forms and documents to provide:

- Photocopy of birth record(s) *(required)*
- Certified copies of divorce decree(s) and/or Domestic Relations Order (DRO) *(if applicable)*
- Photocopy of marriage certificate *(if applicable)*
- *Direct Deposit Agreement (optional, but recommended)*
- Tax Withholding Certificates *(default will apply if you do not complete a Form W-4P and Form W-4MNP.)*

Things to know

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 is approved, you will receive your first payment about six weeks after approval of the benefit. We may pay you retroactively up to 180 days of receipt of your application or from the last day you are paid salary, whichever is later.

If your disability claim is denied, you may appeal the decision in writing within 60 days of the date of the notification letter.

After approval of your disability benefit
Your disability status may be recertified by a medical provider once a year for the first five years and once every three years thereafter until full retirement age.

1. Information about you

Last name	First name	MI	MSRS ID or SSN

Mailing address	Date of birth

City	State	Zip code

Daytime phone number	Alternate phone number

Employing agency/department	Last day physically on the job

Indicate current marital status

- ❒ Single
- ❒ Widowed
- ❒ Married. You must provide photocopy of marriage certificate. Your spouse's notarized signature is required on page 5.

  Spouse's name _____ Spouse's date of birth _____

  - ❒ Check this box if you have ever been divorced. You must provide a certified copy of **all** divorce decree(s) and domestic relations order (DRO), if applicable, even if the benefit will not be divided between the parties.
- ❒ Divorced. You must provide a certified copy of **all** divorce decree(s) and domestic relations order (DRO), if applicable, even if the benefit will not be divided between the parties.

2. Medical information

1. Explain your disabling condition:

❒ Check here if you have attached 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 medical providers most familiar with your disabling condition:

Medical Providers or Clinic	Specialty	Dates of Medical Appointment First	Most Recent

3. Employment and education

6. Tell us about your most recent employment:

Are you currently employed? ❒ Yes ❒ No

Self employed? ❒ Yes ❒ No

If self employed, list your job duties: _____

List your employment history for the past 10 years:

Date	Employer	Job duties

7. Level of education:

❒ High School ❒ Vocational School ❒ College ❒ Advanced Degree

College Degree: _____ (List degree) Advanced Degree: _____ (List degree)

Certificates: _____

Do you have training for other types of employment? ❒ Yes ❒ No

If yes, list type(s) of training: _____

_____

4. Other benefits

8. Are you receiving workers' compensation payments? ❒ Yes ❒ No

9. 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

10. 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). ❒ Yes ❒ No

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

5. Survivor benefit options

The Single-Life benefit provides the highest benefit payment to you. If you select joint-and-survivor coverage or the life income option, you will receive a lower monthly benefit payment to provide this additional coverage. If you select a joint-and-survivor option and your survivor predeceases you, the monthly benefit amount will increase ("bounce back") to the single-life benefit amount after MSRS has been notified of the death and has received the death certificate.

MSRS will send you a benefit authorization letter confirming the monthly benefit amount about the time you receive your first payment. You may change your survivor benefit option *up to 30 days* after the date of the authorization letter. After that, you may not change your selection.

Please select one option.		
❒	Single-Life Benefit	This benefit is for your life only and ends upon your death.
❒	100% Joint-and-Survivor Benefit	Upon your death, your survivor will receive a monthly benefit for their lifetime equal to your benefit amount.
❒	75% Joint-and-Survivor Benefit	Upon your death, your survivor will receive 75% of your monthly benefit for their lifetime.
❒	50% Joint-and-Survivor Benefit	Upon your death, your survivor will receive one-half of your monthly benefit for their lifetime. If you are married, Minnesota law requires that you provide at least a 50% option for your spouse unless they waive survivor coverage.
❒	Life Income, 15-Year Certain	If you die before collecting a monthly benefit for 15 years, your survivor will continue to receive the benefit for the balance of the 15 years. If you die after collecting a benefit for 15 years, your survivor will not receive a benefit.

6. Survivor information

Complete this section if you selected a Joint-and-Survivor Benefit or Life Income, 15-Year Period Certain option in Section 5.

DO NOT COMPLETE THIS SECTION IF YOU SELECTED A SINGLE-LIFE BENEFIT.

Survivor's name	Social Security Number	Relationship to you

You must provide a photocopy of your survivor's birth record if you selected a Joint-and-Survivor Benefit.

7. Spouse's notarized 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.

Only the original application with signature and notary will be processed. A fax or email copy is not acceptable.
The date this form is signed must match the date your signature is notarized. **Note: Notary seal must be visible.**

Spouse's signature _____ Date _____

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

County of _____

State of _____

Notary public's signature _____

8. Applicant's notarized signature

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

Only the original application with signature and notary will be processed. A fax or email copy is not acceptable.
The date this form is signed must match the date your signature is notarized. **Note: Notary seal must be visible.**

Applicant's signature _____ Date _____

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

County of _____

State of _____

Notary public's signature _____

Please complete and sign both of the attached *HIPAA Disclosure* forms.

Participant's Authorization and Acknowledgement

1. HIPAA Disclosure

I, _____ , authorize _____
Your Name *Name of Medical Provider 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 photocopy 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 medical providers to provide MSRS and their medical advisors, including MMRO, with my medical information.

Participant's name (please print): _____

Participant's date of birth: _____

Participant's signature: _____

Date: _____

Mail the completed form to:

Minnesota State Retirement System
60 Empire Drive, Suite 300
St. Paul, MN 55103-3000

Toll-free: **1.800.657.5757**

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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