



Ohio Public Employees Retirement System

277 East Town Street, Columbus, Ohio 43215-4642

1-800-222-PERS (7377) www.opers.org



Disability Benefit Application

Please complete this form in its entirety. Failure to complete this form in its entirety could result in a delay in processing. Managed Medical Review Organization (MMro), OPERS' third party administrator, may be contacting you regarding your application for disability benefits.

This Application must be completed by the member or, if the member is unable to apply due to being physically or mentally incapacitated, by the member's legal guardian or attorney in fact. If a legal guardian or attorney in fact is making application on behalf of the member, Letters of Guardianship or a durable Power of Attorney also must be submitted with this Application.

Disability coverage is limited to illnesses and injuries that occur before a member terminates employment, or illnesses and injuries resulting from the member's employment that become evident up to two years following termination of employment. Disability benefits are available only if a member is found to be mentally or physically incapacitated for the performance of duty of their last position of public employment by a disabling condition, either permanent or presumed to be permanent. If the Application is approved, benefits are effective the first of the month following the later of: 1) the last day for which compensation was paid, or 2) the attainment of eligibility.

Members covered under the original disability plan who are in retirement transition group A or B must file an application for a disability benefit before attaining age 60. The member's last day of public service must also be prior to attaining age 60. Members covered under the original plan who are in retirement transition group C must file an application for a disability benefit before attaining age 62. The member's last day of public service must also be prior to attaining age 62. Members covered under the revised disability plan may file an application for a disability benefit at any age.

If you are approved for a disability benefit, you must be removed from your employer's payroll no later than the end of the month following the month in which the OPERS Board of Trustees' approves the disability benefit application. If you do not terminate public employment within this time frame, your application will be voided, your disability benefit will not be paid and will be forfeited. And, if you are eligible, you will be required to re-apply for a disability benefit.

To be eligible under Ohio retirement law to receive an OPERS disability benefit:

- 1) You must have at least 60 calendar months of OPERS contributing service, unless you are in the law enforcement division.
- 2) If you are in the law enforcement division and become disabled due to an on-duty illness or injury, you are eligible regardless of length of service.
- 3) Your condition must be a presumably permanent disabling condition, either mental or physical, which prevents you from performing the duties of your public employment. You are not eligible for a disability benefit due to a temporary disability. Disability coverage does not extend to illnesses or injuries resulting from elective cosmetic surgery other than reconstructive surgery. Your right to receive a disability benefit may be forfeited if the disability was caused by the commission of a felony.

- 4) If you currently participate in the OPERS Combined Plan and completed the application, OPERS will transfer your individual account to the Traditional Pension Plan upon approval of the disability benefit application. No more than two years have passed since you terminated from or last contributed to the Traditional Pension Plan or the Combined Plan, unless at the end of the two-year period you were physically or mentally incapacitated from making application as proven by your medical records.
- 5) You must not be receiving an age and service retirement benefit from OPERS or any other Ohio Retirement system.

Please refer to the OPERS Member Handbook and the Disability Benefits leaflet for more information, especially regarding the differences between the original and revised disability plans. **(We strongly encourage you to use the online benefit estimator and health care coverage cost estimator to assist you with making your decision to apply for a disability benefit).** If you have questions, you are encouraged to speak with an OPERS member services representative in person or by phone (see address and phone number listed on page 1).

Members receiving a disability benefit that is effective on or after Jan. 1, 2014, will have access to health care coverage for the first five years of their disability based on their continued eligibility and receipt of a disability benefit during that time. Health care coverage for disability recipients will continue past the first five years only if: 1) the recipient meets age and service retirement eligibility requirements for health care or, 2) the recipient enrolled in Medicare, due to a disability, prior to the end of the five years and prior to reaching age 65.

Please note: failure to notify OPERS of your enrollment in Medicare within 30 days of receipt of your eligibility will result in no coverage offered by OPERS

For more information, please refer to the *OPERS Health Care Coverage Guide* available on www.opers.org.

Section 1 - Personal Information - *Unless already on file with OPERS, proof of your date of birth must be submitted with this application.*

Social Security Number

OPERS ID

First Name

MI

Last Name

Suffix

Street or Mailing Address

Apt. Number

City

State

ZIP Code

Date of Birth

Month

Day

Year

Gender

Male

Female

Home Phone Number

Work Phone Number

Cell Phone Number

Preferred Telephone Number for Contact: Home Work Cell

Preferred Time to Call: Morning Afternoon Evening

E-mail Address

Section 2 - Member's Physician Information - *If you have multiple physicians, please have each physician complete a Report of Physician form (DR-APS) on your behalf. The physician must be a licensed and practicing physician (MD or DO). It is important to provide contact information. Please notify us if a physician you have indicated will not be submitting a (DR-APS) on your behalf.*

Physician Name

Physician Office Mailing Address

Suite Number

City

State

ZIP Code

Physician Office Phone Number

Physician Fax Phone Number

MD

DO

Will this physician be submitting a Report of Physician (DR-APS)?

Yes No

Physician Name (2)

Physician Office Mailing Address

Suite Number

City

State

ZIP Code

Physician Office Phone Number

Physician Fax Phone Number

MD

DO

Will this physician be submitting a Report of Physician (DR-APS)?

Yes No

Physician Name (3)

Physician Office Mailing Address

Suite Number

City

State

ZIP Code

Physician Office Phone Number

Physician Fax Phone Number

MD

DO

Will this physician be submitting a Report of Physician form (DR-APS)?

Yes No

Section 3 - Social Security Disability Insurance - *If you are approved for an OPERS Disability Benefit and you are eligible to apply for Social Security Disability Insurance (SSDI), you are required to apply, and provide a copy of the SSDI benefit application, not later than 90 days from the OPERS Board of Trustees approval date of your disability benefit application. This requirement does not apply to members in the OPERS law enforcement division. If you are not sure if you are eligible for an SSDI benefit you can find out by going to www.ssa.gov or by contacting Social Security at 1-800-772-1213.*

Important: *As of Jan. 1, 2014, eligibility for health care coverage through the OPERS Health Care Plan may be limited to the first five years of receiving a disability benefit. To continue health care coverage through OPERS beyond the first five years of disability you may be required to enroll in Medicare due to a disability or meet the minimum age and service requirements. We strongly suggest that you check with the Center for Medicare and Medicaid Services regarding your eligibility for coverage through Medicare. You may qualify for health care coverage through Medicare even if you do not qualify for Social Security Disability Insurance (SSDI).*

Are you currently receiving a Social Security Disability Insurance benefit?

Yes No

Are you eligible to apply for a Social Security Disability Insurance benefit?

Yes No

Do you have at least five years of OPERS service credit for the same periods during which you had earnings from other employment that was taxable under Social Security (FICA tax) for any time period prior to your application for disability benefits?

Yes No

Section 4 - Other Retirement System Service Information - *If you are currently a member or have been a member of any of the following retirement systems, please complete the following. If you have never been a member of one of the retirement systems listed below, please check this box:*

	Currently a member?		Have been a member?
Ohio Police and Fire Pension Fund (OP&F)	<input type="checkbox"/>	or	<input type="checkbox"/>
State Highway Patrol Retirement System (HPRS)	<input type="checkbox"/>	or	<input type="checkbox"/>
Cincinnati Retirement System (CRS)	<input type="checkbox"/>	or	<input type="checkbox"/>
State Teachers Retirement System (STRS)	<input type="checkbox"/>	or	<input type="checkbox"/>
School Employees Retirement System (SERS)	<input type="checkbox"/>	or	<input type="checkbox"/>

If you have refunded from either STRS or SERS, are you interested in purchasing this time to be included in the calculation of your benefit? Yes No

If you have membership with SERS and/or STRS, this credit may be used in the calculation of your OPERS benefit or you may elect to retire on an independent basis using only OPERS service and salary.

Make your choice below.

NO, DO NOT combine my SERS and/or STRS account with my OPERS account.

YES, DO combine my SERS and/or STRS account with my OPERS account.

If you choose to combine your account, the Retirement System with the greatest total service credit will be responsible for processing your application. Furthermore, you must apply for a disability benefit with the Retirement System with the greatest service credit.

Section 5 - Other Service Information

Are you in the process of, or planning to, purchase service credit?

Yes No

If yes, what type? _____

Section 6 - Rehabilitative Services - OPERS offers Rehabilitative Services to our disability benefit recipients to assist them with maximizing their functionality and employability.

Rehabilitative Services consists of clinical and vocational rehabilitation. Clinical Rehabilitative services are to ensure that recipients are undergoing appropriate continued medical treatment, consistent with professional standards of care, to assist recipients in improving their disabling and co-morbid conditions impacting their disabling condition. Vocational rehabilitative services provides a recipient with appropriate vocational resources and tools, including local and state resources, to assist him/her in their efforts to seek employment in the competitive labor market. Before making the selection below it is important for you to read and understand expectations of rehabilitative services. This information can be found in the Disability Benefit booklet. Members in the OPERS law enforcement division are exempt from the any occupation standard and are not required to make a Rehabilitative Services selection.

If you elect to participate in the Rehabilitative Services Program, the medical and vocational information acquired through the Rehabilitative Services Program, may be used in the determination of your continued eligibility for a disability benefit.

If my application is approved, I choose to actively participate in Rehabilitative Services. I understand that by actively participating in Rehabilitative Services I will remain on a leave of absence from my last public employer and continue to be evaluated under the own occupation standard for up to five years following the effective date of my benefit. If at any time after my third benefit anniversary I stop participating in rehabilitative services, my disabling condition will be reviewed immediately under the any occupation standard. Furthermore, I understand that upon the expiration of my leave of absence period I will be evaluated under the any occupation standard.

-OR-

If my application is approved, I choose **not** to participate in Rehabilitative Services. I understand that by not actively participating in Rehabilitative Services my leave of absence from my last public employer will be limited to three years following the effective date of my benefit. Furthermore, I understand that upon the expiration of my leave of absence period I will be evaluated under the any occupation standard.

Section 7 - Education

1) Indicate highest level of education completed:

K-12

Undergraduate Degree: Type _____

Graduate or Professional Degree: Type _____

Technical Degree or Professional Certification: Type _____

2) List all the skills and knowledge you have demonstrated or developed through your education:

3) Computer Experience/Skills (please list below)

Level of Proficiency (please choose one)

a) _____

Low Medium High

b) _____

Low Medium High

c) _____

Low Medium High

d) _____

Low Medium High

e) _____

Low Medium High

Section 8 - Work Experience - Please be sure to complete the information listed below. Please list all job titles/positions held in the last 10 years, beginning with the most recent. The information below should be for any job you have worked, and not limited to just OPERS covered employment. If you are using additional pages to list work experience please check this box:

Work Experience #1

Dates of Employment: From

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

 To

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

Job title and brief description of job duties:

Work Experience #2

Dates of Employment: From

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

 To

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

Job title and brief description of job duties:

Work Experience #3

Dates of Employment: From

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

 To

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

Job title and brief description of job duties:

Section 9 - Military Experience

Are you a veteran?

Yes No

If yes, provide dates of service?

From:

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

 To:

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

List any special skills or training:

Section 10 - Volunteer Experience - Please list your volunteer experience beginning with your most recent experience. If you are using additional pages to list volunteer experience, please attach those to the application and check this box:

1) Volunteer Experience

Brief description of all volunteer position(s):

List all of the skills you have demonstrated through this position(s):

Section 13 - Member's Authorization and Acknowledgment

HIPAA DISCLOSURE:

I authorize any licensed physician, medical provider, medical facility or provider of health care or similar entity to release any and all of the following information to OPERS or its third party administrators. I understand if there are any expenses for releasing this information it is my responsibility to pay those expenses.

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 to employment opportunities, and assessment of ongoing treatment. Any information obtained will not be released to any person or organization except OPERS and its third party administrators.

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 next to my signature below.

I understand I have the right to revoke this Authorization at any time by notifying OPERS.

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

Being duly sworn, I, the undersigned, state that the information I provided in this Application is complete and true to the best of my knowledge and belief. I understand that, by applying for disability benefits, I am consenting to undergo medical examinations by an OPERS-appointed, independent medical examiner(s) and authorize my physician(s) to provide OPERS with my medical information.

I acknowledge that, if my application is approved, I must terminate public employment not later than the month following the month in which the OPERS Board approves my application. I acknowledge that if I do not terminate public employment within this time frame, my application will be void, my disability benefit will not be paid and will be forfeited, and, if I am eligible, I may file a new disability application.

I acknowledge that I have received and reviewed the OPERS Disability Benefits leaflet and the Member Handbook concerning disability benefits. If I am approved by the OPERS Board for disability benefits, I acknowledge that this approval may be contingent upon my receiving continued medical treatment for my disabling condition. Additionally, I acknowledge that my disability benefits will be terminated should I return to public employment or service as an elective official.

Member Signature _____
Do not print or type name

Today's Date		
Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

Sworn and subscribed to me this _____ day of _____, 20_____

Notary Signature _____ My commission expires _____

