SCERS
SACRAMENTO COUNTY EMPLOYEES' RETIREMENT SYSTEM

DISABILITY RETIREMENT APPLICATION INSTRUCTIONS

(Use these Instructions to help you complete and submit your Disability Retirement Application Form)

Completing the Application Form

1. Type or print your information legibly. You must initial, sign, and date the Application where indicated and submit it in person or by mail to SCERS in hard copy.

2. You must complete each of the items numbered 1 through 34 by entering the required information and/or checking the appropriate boxes, or entering "N/A" for a numbered item that does not apply to your Application. You must also initial, sign, and date your Application where indicated. An incomplete Application that does not include your initials, signature or date where required will not be accepted by SCERS and will be returned to you.

Application Section Title	Item Number	Instructions
Member Information	1 thru 5	Provide complete information to ensure you receive timely communication regarding your Application throughout the process. You must update your contact information with SCERS if there are any changes after your Application is submitted.
Disability Retirement Type	6	You may apply for either or both Service-Connected (job-related) or Non Service-Connected (not job-related) Disability Retirement. If you check only the Service-Connected Disability Retirement box, you will also be considered for Non Service-Connected Disability Retirement, if eligible.
Reciprocal System(s)	7	If you are a deferred or active member of one or more other public retirement systems in California, identify the Reciprocal System(s) and indicate whether you have also filed an application for disability retirement with those Reciprocal System(s). This will enable SCERS to appropriately coordinate benefits with the Reciprocal System(s) as required by law if you are granted a disability retirement.

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Application Section Title	Item Number	Instructions
Employment Information	8 thru 12	Provide the name of your SCERS participating employer (Sacramento County, Superior Court, or special district), department, position or job classification title, the current status of your SCERS-covered employment, and the effective date of that status. Also provide a history of <u>any</u> other employment you have had since the onset of the injury(ies) or disease(s) you are claiming that cause you to be permanently incapacitated for the performance of duty, including employment <u>not</u> covered by SCERS. This information will assist SCERS in counseling you on your potential disability retirement benefits and in determining the effective date of your disability retirement, if granted. NOTE: If you discontinued service **more than four months ago**, you must submit medical evidence substantiating that you have been continuously disabled since the time you discontinued service**.** Discontinued Service means the last date for which a Member earned Regular Compensation from a Participating Employer from which retirement contributions were deducted by SCERS. **If such evidence is not provided, you are not eligible to apply for disability retirement benefits from SCERS and SCERS will <u>not</u> accept your Application.**
Description of Claimed Injury(ies) or Disease(s)	13 thru 16	Answer all of the questions regarding the physical or mental condition(s) you are claiming that cause you to be permanently incapacitated and the impact of such conditions on the performance of your job duties. If you are claiming more than one injury or disease, you may list them all in your Application. <u>Only</u> the claimed injury(ies) or disease(s) you list, <u>and</u> for which you provide medical evidence substantiating the condition exists and permanently incapacitates you for performing your job duties, will be considered by SCERS in evaluating the Application. Identify all the injury(ies) or disease(s) you are claiming permanently incapacitate you when you first complete this application, as you must file an amended or new application to include additional injuries or diseases later, which could delay the processing of your Application.
Service Connection	17 and 18	You must complete this section if you checked the "Service-Connected Disability Retirement" box in Item 6. Provide thorough information including dates, locations and circumstances to substantiate your claim that your injury(ies) or disease(s) arose out of and in the course of your employment.
Required Attachments	19	Carefully review this list of required attachments to ensure that you obtain and submit all of the documentation needed to ensure your Application is complete. **SCERS will <u>not</u> pay for or reimburse you for any costs associated with obtaining the required documentation.**
Claims Against Third Parties	20	Complete this section if any of the injuries or diseases you claim permanently incapacitate you for the performance of duty resulted from the action(s) of a third party other than your employer.

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Application Section Title	Item Number	Instructions
Other Claims Filed	21	Provide information on any other claims you have filed, such as litigation, settlements, Workers' Compensation, state disability, or Social Security disability, because of the claimed injury(ies) or disease(s) identified in your application.
Medical Treatment Providers	22	List all medical professionals and/or facilities from which you have received treatment **within the last five years** for the claimed injury(ies) or disease(s) you listed in Items 13 and 17. For each medical professional or facility, provide the name, address, phone number, treatment specialty and the dates or time period during which you were treated. You may attach additional pages if needed.
Request for Earlier Effective Date	23	If your Application is granted, your disability retirement will be effective on the later of the Application Date or the day after you discontinued service. You may request an Earlier Effective Date by completing this section of the Application form and providing the additional required documentation. With this documentation, you must prove that you qualify for an Earlier Effective Date because your Application was delayed: 1) by administrative oversight or 2) due to the fact that the permanency of your incapacity could not be determined at the time you discontinued service.
Applicant's Acknowledgments, Representations and Declarations	24 thru 34	You must read and initial each of the statements in this section of your application**. If any portion of this section is incomplete, your application will <u>not</u> be accepted by SCERS and will be returned to you.** You must correct the deficiency and resubmit your application and accompanying documents for SCERS to accept your application.
Applicant's Signature	35	You must sign the application under penalty of perjury, print your name below your signature, and enter the date. **An unsigned application will <u>not</u> be accepted by SCERS and will be <u>returned</u> to you.**

<u>Submitting Your Application to SCERS</u>

3. Review each page of your Application form to ensure it is accurate and complete, that you have read and initialed each of the Items numbered 24 through 34, and have printed your name, and signed and dated your Application at Item 35. Retain a copy of your completed Application form for your records.
4. Assemble all of the completed documents in the following order:
    - Disability Retirement Application form
    - Member's Examining Physician Report

      <u>If applicable</u>:

      - Medical evidence substantiating continuous disability since Discontinuation of Service
      - Documentation substantiating Request for Earlier Effective Date
    - Authorization for Release of Medical and Other Information form

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5. If you have scheduled an appointment to meet in person with a SCERS Disability Retirement Unit staff member to discuss the application process, bring the packet you assembled as described in instruction 4 above to that appointment.

6. If you are delivering or mailing your application to SCERS, place the packet you assembled as described in instruction 3 above, unfolded, in a large mailing envelope addressed to:

   Sacramento County Employees' Retirement System (SCERS)
   980 9th Street, Suite 1900
   Sacramento, CA 95814
   Attn: Disability Retirement Unit

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SACRAMENTO COUNTY EMPLOYEES' RETIREMENT SYSTEM

DISABILITY RETIREMENT APPLICATION

(Type or print legibly. Refer to the Instructions for help completing the Disability Retirement Application)

MEMBER INFORMATION

1. Social Security Number: - -

2. Member's Name:

_____

Last *First* *Middle*

List below any other names you have used or been known by:

3. Address:

_____

Number *Street* *Unit/Apt.*

_____

City *State* *Zip Code*

4. Phone Numbers:

Home: ( ) _____-_____ Work: ( ) _____-_____

Mobile: ( ) _____-_____ Other: ( ) _____-_____

Email address: _____

5. Date of Birth:

_____/_____/_____

MM DD YYYY

DISABILITY RETIREMENT TYPE

6. Type of disability retirement you are applying for:
(you may check either or both boxes)

❑ **Service-Connected Disability Retirement (SCDR)**
If you check SCDR box only, you will also be considered for NSCDR, if eligible.

❑ **Non Service-Connected Disability Retirement (NSCDR)**
You must have at least five (5) years of full-time service credit to be eligible (including reciprocal service)

RECIPROCAL SYSTEM(S)

7. Are you a member of another public retirement system (Reciprocal System) in California? ❑ Yes (list below) ❑ No *(proceed to Item 8)*

Reciprocal System(s): _____

_____

Are you a deferred member of SCERS who is filing or has filed for disability retirement as an active member of a Reciprocal System(s) listed above?

❑ Yes– Skip the remaining questions and sign and file this Application with SCERS. SCERS will await verification of the Reciprocal System's determination on your disability retirement application.

❑ No – Fully complete, sign, and submit this Application and required attachments to SCERS.

For SCERS Use Only

Date Submitted: _____

Years of Service: _____

Membership: ❑ Miscellaneous ❑ Safety

Benefit Tier: _____

Age at Filing: _____

Completed Date: _____

Board Action: _____

Action Date: _____

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EMPLOYMENT INFORMATION

8. SCERS Participating Employer:

9. Department Name:

10. Position/Job Classification:

11. SCERS-Covered Employment Status: **Date that Status Began:**

- ❑ Still working ❑ full-time ❑ part-time _____/_____/_____
- ❑ Leave with pay _____/_____/_____
- ❑ Leave without pay _____/_____/_____ *
- ❑ Terminated Employment _____/_____/_____ *
- ❑ Retired for Service** _____/_____/_____ *
- ❑ Other: _____ _____/_____/_____

* **If more than four months has elapsed since the date you discontinued service**, you must submit medical evidence substantiating that you have been continuously incapacitated for the performance of duty from the date you discontinued service. If such evidence is not provided, you are not eligible to apply for disability retirement benefits from SCERS and SCERS will not accept your Application.

** **If you have already retired for service when you apply for disability retirement**, the beneficiary you named and option you elected when you retired for service will apply to your disability retirement benefit if your disability retirement application is granted.

12. List below <u>any</u> other employment you have had since the onset of the injury(ies) or disease(s) you are claiming cause you to be permanently incapacitated for the performance of duty:

Employer Name	Employer Address	Job Title	Begin Date	End Date

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DESCRIPTION OF CLAIMED INJURY(IES) OR DISEASE(S)

When responding to any of the following questions, you may attach additional pages if necessary.

13. List the physical and/or mental condition(s), including each part of your body affected by such conditions(s), you are claiming that cause you to be permanently incapacitated for the performance of your duties. Any condition(s) you list here that are not supported by medical evidence in the Member's Examining Physician Report (which you are to provide as an attachment to this Application) will not be considered by SCERS in evaluating your Application for disability retirement benefits.

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14. List your usual duties for your position.

15. List the usual duties of your position that you claim you can no longer perform because of the injury(ies) or disease(s) listed in Item 13 that you claim permanently incapacitate you for the performance of those duties.

16. List the usual duties of your position that you are still able to perform.

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SERVICE CONNECTION

(If you are <u>not</u> applying for SCDR, you may respond "N/A" to Items 17 & 18 below)

17. Are you claiming that all of the injuries or diseases listed in Item 13 arose out of and in the course of your employment?

❑ Yes (proceed to Item 18) ❑ No – Please list below each injury or disease you claim is service-connected

18. For each injury or disease you claim is service-connected, describe how you believe it was caused or exacerbated by your employment. Include dates, locations, and circumstances as applicable.

REQUIRED ATTACHMENTS

19. The following documentation **<u>must</u>** be submitted with your Application:

- **Member's Examining Physician Report** completed and signed by a physician
- **Authorization for Release of Medical and Other Information**
  You must complete, sign, and submit this form with your Application to enable SCERS to obtain medical and other records needed to evaluate and make a determination on your Application
- **Any additional documentation required if:**
  - The Application is filed more than four months after the date the Member discontinued service (see footnote in Item 11 of this Application)
  - An Earlier Effective Date is requested in Item 23 of this Application

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CLAIMS AGAINST THIRD PARTIES

20. Are any of the injuries or diseases that you claim permanently incapacitate you for the performance of duty the result of the action(s) of a third party other than your employer?

❑ Yes (identify and explain below) ❑ No (proceed to item 21)

Name of Third Party:

Explanation of cause(s) and circumstance(s):

OTHER CLAIMS FILED

21. Have you made any other claims (e.g., lawsuits, settlements, Workers' Compensation, state disability, Social Security disability) because of the claimed injury(ies) or disease(s) you identified in this Application?

❑ Yes (provide information below) ❑ No (proceed to item 22)

Entity/Type of Claim You Filed	Claim # or Reference	Date of Claim

MEDICAL TREATMENT PROVIDERS

22. List all medical professionals and/or facilities from which you have received treatment **within the last five years** for the injury(ies) or disease(s) you listed in Items 13 and 17. For each medical professional or facility you list, you must provide all of the following information: (You may attach additional pages if needed)

NAME	ADDRESS	PHONE	TREATMENT SPECIALTY	TREATMENT DATES

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REQUEST FOR EARLIER EFFECTIVE DATE

23. If your Application is granted, your disability retirement will be effective on the later of the Application Date or the day after you discontinued service. You may request an Earlier Effective Date by completing paragraphs **a. through d.** below, and providing the additional required documentation.

Are you requesting an earlier effective date for this Application, if granted?

❑ Yes – Complete paragraphs a through d below and submit all required documentation with this Application

❑ No – Proceed to item 24

a. Date You Discontinued Service: _____/_____/_____

b. Was the filing of your Application delayed by administrative oversight?

❑ Yes – You **must** attach documentation explaining and substantiating the administrative oversight that delayed the filing of the Application.

❑ No

c. Was the permanency of your incapacity able to be determined at the time you discontinued service?

❑ Yes

❑ No – You **must** attach medical evidence substantiating your claim that the permanency of your incapacity could not be determined at the time you discontinued service.

d. Have you been continuously incapacitated for the performance of duty since the date you discontinued service?

❑ Yes – You must attach medical evidence substantiating that you have been continuously incapacitated for the performance of duty. (proceed to Item 24)

❑ No

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MEMBER APPLICANT'S ACKNOWLEDGMENTS, REPRESENTATIONS AND DECLARATIONS

You must read and initial each of the statements in Items 24 through 34, and sign and date this Application under penalty of perjury at Item 35. ***SCERS will not accept your Application if any item in this section is incomplete****.*

24. I acknowledge and understand that as the Applicant, I have the burden of proving by a preponderance of the medical evidence that I am permanently incapacitated for the performance of the duties of my position.

_____ *Member/Applicant's initials*

25. I acknowledge and understand that if I am applying for a service-connected disability retirement, I also have the burden of proving by a preponderance of the medical evidence that my permanent incapacity for the performance of duty was caused or exacerbated by injury(ies) or disease(s) arising out of and in the course of my employment, and that my employment substantially contributed to my disability.

_____ *Member/Applicant's initials*

26. I represent that the injury(ies) or disease(s) I claim in this Application cause me to be permanently incapacitated for the performance of duty are not due to my intemperate use of alcohol, drugs, willful misconduct, or violation of law.

_____ *Member/Applicant's initials*

27. I acknowledge and understand that I am required to submit with this Application a Member's Examining Physician Report in a format prescribed by SCERS that is completed and signed by a physician. I further acknowledge and understand that if the completed Member's Examining Physician Report(s) submitted to SCERS do not substantiate that one or more of the claimed injuries or diseases listed in Item 13 incapacitate me for the performance of my duties, SCERS is unable to process my Application and my Application will be dismissed. I further acknowledge and understand that only the claimed injury(ies) or disease(s) for which SCERS has received medical evidence substantiating the injury or disease exists and incapacitates me for the performance of my duties will be given further consideration in SCERS' evaluation of my Application.

_____ *Member/Applicant's initials*

28. I acknowledge and understand that if **more than four months has elapsed since the date I discontinued service and the date I submit this Application**, I must submit medical evidence substantiating that I have been continuously disabled since the time I discontinued service. I further acknowledge and understand that if such medical evidence is not provided, I am not eligible to apply for disability retirement benefits from SCERS and my application will not be accepted.

_____ *Member/Applicant's initials*

29. I acknowledge and understand that I am responsible for arranging for and providing my written authorization to the medical professionals and/or facilities I listed in Item 22 to provide my medical records and reports directly to SCERS within 60 days of the date I submit this Application. I further acknowledge and understand that I may submit to SCERS a written request for an extension of time in the event one or more medical professionals and/or facilities has not provided my medical records and reports to SCERS within 60 days of the date I submit this Application.

_____ *Member/Applicant's initials*

30. I acknowledge and understand that I am obligated to cooperate fully with SCERS in its evaluation of my Application, including responding timely to requests for additional information or records, and submitting to an Independent Medical Evaluation, if referred. I further acknowledge and understand that if I fail to cooperate, my Application may be dismissed.

_____ *Member/Applicant's initials*

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31. I acknowledge and understand that I am not required but, at my option and expense, I may consult with and/or retain legal counsel with regard to this Application and my claim for disability retirement benefits. If I retain legal counsel, I or my attorney must promptly file a written notice of representation with SCERS.

_____ *Member/Applicant's initials*

32. I acknowledge and understand that if I am eligible, I may apply for and receive a service retirement allowance pending a determination on my Application for disability retirement. If my Application is later denied, I understand that I will continue to receive my service retirement from SCERS.

_____ *Member/Applicant's initials*

33. I acknowledge and understand that if I am already retired for service when I apply for disability retirement, the beneficiary I named and option I elected when I retired for service will apply to my disability retirement benefit if my Application is granted.

_____ *Member/Applicant's initials*

34. I acknowledge and understand that, if granted, my disability retirement allowance will be effective on the date I submitted this signed Application to SCERS, but no earlier than the day after the last day for which I receive regular compensation (including compensated sick leave or vacation, etc.). I also understand that I may request an earlier effective date by completing Item 23 and proving that the filing of my Application was delayed by administrative oversight or inability to ascertain the permanence of my incapacity until after the last date for which I received regular compensation.

_____ *Member/Applicant's initials*

35. I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION I HAVE PROVIDED IN THIS APPLICATION IS TRUE AND CORRECT.

_____ _____

Member/Applicant's Signature *Date Signed*

_____

Printed Name

ONLY FOR APPLICATIONS FILED ON BEHALF OF A SCERS MEMBER BY ANOTHER PERSON

Applicant's Name: **Relationship to Member:**

_____ _____

Last *First* *Middle*

Applicant's Address:

_____

Number *Street* *Unit/Apt* *City* *State* *Zip Code*

Applicant's Phone Numbers: Work: ( ) _____-_____ Mobile: ( ) _____-_____

Applicant's Email Address: _____

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION I HAVE PROVIDED IN THIS APPLICATION IS TRUE AND CORRECT.

_____ _____

Applicant's Signature *Date Signed*

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