Name _____
Last *First* *MI*

☐ Accidental ☐ Ordinary ☐ Both

Disability Retirement Application

INSTRUCTIONS

- In order to apply for disability benefits, you must complete the questions and forms contained in this application. This application consists of:
  - ☐ Overview of disability retirement benefits . . . . . i–iv
  - ☐ Overview of retirement options and calculation worksheet . . . . . v–vi
  - ☐ Information and answers you must provide 1–16
  - ☐ Authorizations for release of information
    - Insurance records 17
    - Protected health information 18
    - Tax records 19
  - ☐ Medical Panel selection form 20
  - ☐ Applicant's Physician's Statement 21–26
- If you have any questions or need clarification, please contact our Disability Case Manager for help.
- **Do not delete any pages from this application. If necessary, please attach additional sheets.**
- **As required, please print your responses legibly, in ink.**
- The ☑ symbol means that you must submit the document listed in the margin along with your application.
- Be sure to **complete the entire application,** including the release forms, and attach all required documents before returning your application to our office. **If your application is incomplete, we will return it to you and this will delay processing.** We cannot assign a date of application—which is very important in determining the effective date of your retirement if your application is approved—until you have submitted all required information. Your supporting physician's completed statement must be submitted at the same time that you file your application or your application will be considered incomplete and your effective date of retirement will not be determined.
- Before you send the application and your documents to us, make a photocopy of all pages for your records.
- After you have completed this application, gathered the required documents and made a photocopy for your records, please send your materials to:

  Disability Case Manager
  Massachusetts Teachers' Retirement System
  500 Rutherford Ave., Suite 210
  Charlestown, MA 02129-1628

MAIN OFFICE
500 Rutherford Ave., Suite 210
Charlestown, MA 02129-1628
Phone 617-679-MTRS (6877)
Fax 617-679-1661

WESTERN REGIONAL OFFICE
One Monarch Place
Springfield, MA 01144-2048
Phone 413-784-1711
Fax 413-784-1707

ONLINE
mass.gov/mtrs

MTRS
MASSACHUSETTS TEACHERS' RETIREMENT SYSTEM

Form-DRA-12202017

☐ Accidental ☐ Ordinary ☐ Both

OVERVIEW OF DISABILITY RETIREMENT BENEFITS

Accidental Disability Retirement Benefits

What are the eligibility requirements to apply for an accidental disability retirement allowance?

You must have:

- been a member in service at the time that you sustained the personal injury or were exposed to the hazard that caused you to become permanently disabled, and
- sustained the personal injury or been exposed to the hazard while in the performance of your duties.

What will I receive if I am granted an accidental disability retirement allowance?

An accidental disability retirement allowance is made up of two components:

- **an annuity,** a sum based on your contributions to the MTRS and the interest on those contributions, and
- **a regular pension,** an amount equal to 72% of your yearly compensation as of the date you were injured.

For example, a teacher whose regular compensation was $50,000 on the date of the work-related injury that resulted in her permanent disability, and who had a balance of $68,000 in her annuity savings account, would receive an accidental disability retirement allowance of $41,165.28 per year.

Annuity Component	+	Pension Component	=	Accidental Disability Allowance
$5,165.28 (annual portion)	+	$36,000 (72% x $50,000)	=	$41,165.28/year

Please note that this is only an example of the calculation of an accidental disability retirement allowance.

Note: If you were hired after January 1, 1988, your disability benefits will be capped at 75% of your yearly compensation as of the date you were injured. This means that your total accidental disability allowance—the annuity component plus the pension component—may not exceed 75% of your last salary.

Will I receive additional benefits on behalf of my children?

Yes—if you have any dependent children you will receive an additional benefit of $450 per year per child, plus all of the cost-of-living adjustment increases paid since 1988. As of July 1, 2016, the additional annual benefit for eligible children was $871.56.

A dependent child is a child under age 18 or a child of any age who is physically or mentally incapacitated from earning. If your child reaches age 18 and then continues his or her education on a full-time basis, the stipend will continue until he or she reaches age 22. The MTRS will verify that your child is a full-time student every semester until he or she reaches age 22.

I am purchasing creditable service on the MTRS's installment payment plan. If I am granted an accidental disability retirement before the end of the installment plan term—and no longer need any additional creditable service—am I eligible for a refund of the money I have already paid?

No. Internal Revenue Code provisions would prohibit a return of any amounts of contributions already received into your MTRS annuity savings account. However, in many cases, you would *not* be required to purchase the remaining outstanding service. If this question applies to you, please contact the MTRS for additional information.

☐ Accidental ☐ Ordinary ☐ Both

OVERVIEW OF DISABILITY RETIREMENT BENEFITS *(continued)*

Does participation in RetirementPlus affect the calculation of an accidental disability retirement allowance?

No. If you elected to participate in RetirementPlus and have accrued 30 years of creditable service, at least 20 of which are teaching membership service, your accidental disability retirement benefit will be calculated as described on the previous page. However, you will not receive a refund of the difference between the 11% contribution rate and your former rate or any accelerated payments already made.

If you elected to participate in the RetirementPlus program but do not yet have 30 years of creditable service, your accidental disability retirement benefit will be calculated as described above and the difference between the 11% and your former rate of contribution or the amount of accelerated payments already made, will be refunded to you.

Ordinary Disability Retirement Benefits

What are the eligibility requirements to apply for an ordinary disability retirement allowance?

You are eligible to apply for ordinary disability benefits if you are:

- a military veteran, with at least 10 years of creditable service *or*
- not a military veteran, and in:
  - Tier 1 (effective date of membership before April 2, 2012), and under age 55 with at least 10 years of service.
  - Tier 2 (effective date of membership on or after April 2, 2012), and under age 60 with at least 10 years of service.

What will I receive if I am granted an ordinary disability retirement allowance?

The ordinary disability retirement allowance is calculated differently depending on whether you are a non-veteran or a veteran, and whether you are participating in RetirementPlus and eligible to receive the benefit of that program.

- **Non-veteran, non-RetirementPlus participant**

  If you are in Tier 1, and under the age of 55, the allowance is calculated as if you had retired at 55. If you are in Tier 2, and under the age of 60, the allowance is calculated as if you had retired at age 60. If you are age 55 (Tier 1) or age 60 (Tier 2) or over, your allowance is calculated according to your actual age. If you are under the age of 55 (or 60) this works in your favor because, according to the retirement formula, the older you are, the higher the multiplication factor and the higher your benefit amount. While your age is advanced for calculation purposes, you receive credit only for the actual amount of service you have accrued as of the date of your retirement.

  For example, if you are in Tier 1 and, retire under an ordinary disability at age 45 with 20 years of creditable service, and a three-year salary average of $50,000, you would receive $15,000 per year.

Age Factor (Age 55)	x	Number of Years of Creditable Service	=	Percentage of Salary Average
0.015	x	20	=	30%

Allowable Percentage of Salary Average	x	3-Year Salary Average	=	Non-veteran, Ordinary Disability Allowance (Option A amount)
30%	x	$50,000	=	$15,000/year

- **Non-veteran, RetirementPlus participant and eligible to receive the RetirementPlus benefit**

  If you elected to participate in RetirementPlus and have accrued 30 or more years of creditable service—at least 20 of which are teaching membership service—your allowance is calculated in the same way described above, with the exception that you receive the additional RetirementPlus percentage.

NOTE: for the retirement factor tables and a worksheet you can use to estimate your benefits, please see page vi.

☐ Accidental ☐ Ordinary ☐ Both

OVERVIEW OF DISABILITY RETIREMENT BENEFITS *(continued)*

For example, if you are in Tier 1 and retire under an ordinary disability at age 54 with 30 years of creditable service, and a three-year salary average of $50,000, you would receive $28,500 per year.

Age Factor (Age 55)		Number of Years of Creditable Service		Percentage of Salary Average
0.015	x	30	=	45%

Percentage of Salary Average		RetirementPlus Percentage (if any)		Allowable Percentage of Salary Average
45%	+	12%	=	57%

Allowable Percentage of Salary Average		3-Year Salary Average		Non-veteran, RetirementPlus Ordinary Disability Allowance (Option A amount)
57%	x	$50,000	=	$28,500

■ Non-veteran, RetirementPlus participant and ineligible to receive the RetirementPlus benefit

If you elected to participate in the RetirementPlus program but have not yet accrued 30 years of creditable service—at least 20 of which are teaching membership service—your ordinary disability retirement benefit will be calculated as described for a non-veteran, non-RetirementPlus participant, above. In addition, you will receive a refund of your RetirementPlus contributions equal to the difference between the 11% rate and your former rate of contribution, plus any accelerated payments you may have made. If, however, you have accumulated a total of at least 30 years of creditable service, you will not be eligible for a refund of your RetirementPlus contributions.

■ Veteran, non-RetirementPlus participant

You receive a higher ordinary disability retirement benefit than a non-veteran. Your benefit is equal to a yearly annuity amount *plus* one-half of your salary for the last twelve months during which you were actually employed. Your yearly annuity amount is based on the total of your contributions to the retirement system and your interest on those contributions.

For example, if your salary for the last year was $50,000 and the balance in your annuity savings account was $68,000, you would receive an annual allowance of $30,165.28.

Annuity Component		Pension Component		Ordinary Disability Allowance
$5,165.28 (annual portion)	+	$25,000 (50% x $50,000)	=	$30,165.28/year

■ Veteran, RetirementPlus participant and eligible to receive the RetirementPlus benefit

If you elected to participate in the RetirementPlus program and have accrued 30 or more years of creditable service—at least 20 of which are teaching membership service—you will receive the higher of *either* the RetirementPlus benefit (as calculated above for a non-veteran, RetirementPlus participant and eligible to receive the RetirementPlus benefit) *or* the ordinary disability retirement benefit for a veteran, non-RetirementPlus participant.

■ Veteran, RetirementPlus participant and ineligible for the RetirementPlus benefit

If you elected to participate in the RetirementPlus program but have not yet accrued 30 years of creditable service—at least 20 of which are teaching membership service—your ordinary disability retirement benefit will be calculated as described for a Veteran, non-RetirementPlus participant, above. In addition, you will receive a refund of your RetirementPlus contributions equal to the difference between the 11% rate and your former rate of contribution, plus any accelerated payments you may have made. If, however, you have accumulated a total of at least 30 years of creditable service, you will not be eligible for a refund of your RetirementPlus contributions.

Overview of retirement Options A, B and C, tables and factors, and benefit estimate worksheet

Overview of retirement Options A, B and C

The Massachusetts Retirement Law (M.G.L. c. 32) regulates your retirement allowance and allows you to choose one of three benefit options. These options differ with regard to the amount paid and whether any benefits will be paid to someone else after your death.

Option	Monthly benefit amount	Survivor benefit
A	Maximum allowance	None; all allowance payments cease upon your death and no benefits will be provided for any survivors.
B	Approximately 1% less than Option A amount *However, the older you are at retirement, the higher the reduction percentage will be.*	One-time, lump-sum payment of balance, if any, remaining in member's annuity savings account *Note: There are no restrictions on who or how many individuals or entities may be named as beneficiary. In most cases, the member's annuity account will be depleted 9 to 11 years after his or her retirement date.*
C	Approximately 9–11% less than Option A amount	A monthly survivor benefit, equal to 2/3 of the retiree's monthly benefit at the time of death, paid to one beneficiary. *Note: Beneficiary must be the member's parent, child, sibling, spouse or former spouse who has not remarried.*

Option A age factor table

Your age on your retirement date	Your Membership Tier		
	Tier 1 *Established membership before 4/2/2012*	**Tier 2** *Established membership on or after 4/2/2012*	
		With less than 30 years of creditable service	With 30 years or more of creditable service
41	0.001	Tier 2 members are not eligible to retire until age 60	
42	0.002		
43	0.003		
44	0.004		
45	0.005		
46	0.006		
47	0.007		
48	0.008		
49	0.009		
50	0.010		
51	0.011		
52	0.012		
53	0.013		
54	0.014		
55	0.015		
56	0.016		
57	0.017		
58	0.018		
59	0.019		
60	0.020	0.0145	0.01625
61	0.021	0.0160	0.01750
62	0.022	0.0175	0.01875
63	0.023	0.0190	0.02000
64	0.024	0.0205	0.02125
65	0.025	0.0220	0.02250
66	0.025	0.0235	0.02375
67+	0.025	0.0250	0.02500

RetirementPlus percentage table

If you are participating in RetirementPlus, add the percentage that corresponds to your number of **full years** of creditable service (e.g., if you have 32.8 years of service, your RetirementPlus percentage is the percentage listed for 32 years, not 33 years.

Your full years of creditable service	Your Membership Tier	
	Tier 1 *Established membership before 4/2/2012*	**Tier 2** *Established membership on or after 4/2/2012*
30	12%	14%
31	14%	16%
32	16%	18%
33	18%	20%
34	20%	22%
35	22%	24%
36	24%	26%
37	26%	28%
38	28%	30%
39	30%	32%
40	32%	34%

For the Option C factor table, see page 32.

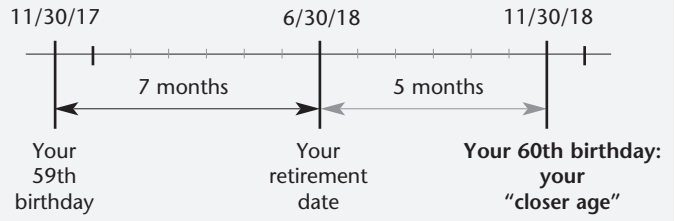
Option C factor table

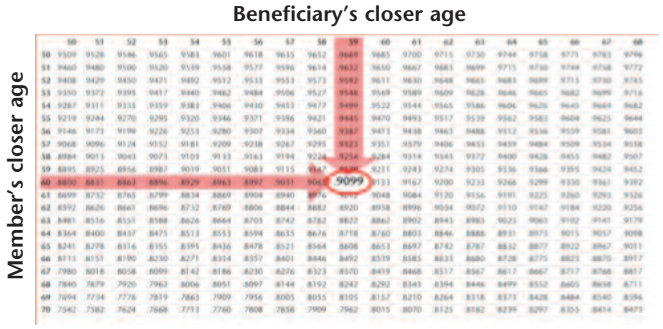
To obtain your Option C factor, determine what your age will be *on your birthday closer to your retirement date;* then determine what your beneficiary's age will be *on his or her birthday that is closer to your retirement date.* Your Option C factor is the number where the row and column for your ages intersect. If the combination of your ages is not listed here, please visit our website at mass.gov/mtrs or contact us for the appropriate factor.

To determine your "closer age," count the number of months and days between your birthday before your date of retirement, and your next birthday *after* your date of retirement. Your "closer age" is your age on your birthday that is closer to your date of retirement.

For example, if you are retiring on June 30, and your birthday is November 30, your "closer age" is your age on your birthday *after* your retirement date.

Determining your and your beneficiary's "closer" ages





Beneficiary's closer age

Member's closer age	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68
50	.9509	.9528	.9546	.9565	.9583	.9601	.9618	.9635	.9652	.9669	.9685	.9700	.9715	.9730	.9744	.9758	.9771	.9783	.9796
51	.9460	.9480	.9500	.9520	.9539	.9558	.9577	.9596	.9614	.9632	.9650	.9667	.9683	.9699	.9715	.9730	.9744	.9758	.9772
52	.9408	.9429	.9450	.9471	.9492	.9512	.9533	.9553	.9573	.9592	.9611	.9630	.9648	.9665	.9683	.9699	.9715	.9730	.9745
53	.9350	.9372	.9395	.9417	.9440	.9462	.9484	.9506	.9527	.9548	.9569	.9589	.9609	.9628	.9646	.9665	.9682	.9699	.9716
54	.9287	.9311	.9335	.9359	.9383	.9406	.9430	.9453	.9477	.9499	.9522	.9544	.9565	.9586	.9606	.9626	.9645	.9664	.9682
55	.9219	.9244	.9270	.9295	.9320	.9346	.9371	.9396	.9421	.9445	.9470	.9493	.9517	.9539	.9562	.9583	.9604	.9625	.9644
56	.9146	.9173	.9199	.9226	.9253	.9280	.9307	.9334	.9360	.9387	.9413	.9438	.9463	.9488	.9512	.9536	.9559	.9581	.9603
57	.9068	.9096	.9124	.9152	.9181	.9209	.9238	.9267	.9295	.9323	.9351	.9379	.9406	.9433	.9459	.9484	.9509	.9534	.9558
58	.8984	.9013	.9043	.9073	.9103	.9133	.9163	.9194	.9224	.9254	.9284	.9314	.9343	.9372	.9400	.9428	.9455	.9482	.9507
59	.8895	.8925	.8956	.8987	.9019	.9051	.9083	.9115	.9147	.9179	.9211	.9243	.9274	.9305	.9336	.9366	.9395	.9424	.9452
60	.8800	.8831	.8863	.8896	.8929	.8963	.8997	.9031	.9065	.9099	.9133	.9167	.9200	.9233	.9266	.9299	.9330	.9361	.9392
61	.8699	.8732	.8765	.8799	.8834	.8869	.8904	.8940	.8976	.9012	.9048	.9084	.9120	.9156	.9191	.9225	.9260	.9293	.9326
62	.8592	.8626	.8661	.8696	.8732	.8769	.8806	.8844	.8882	.8920	.8958	.8996	.9034	.9072	.9110	.9147	.9184	.9220	.9256
63	.8481	.8516	.8551	.8588	.8626	.8664	.8703	.8742	.8782	.8822	.8862	.8902	.8943	.8983	.9023	.9063	.9102	.9141	.9179
64	.8364	.8400	.8437	.8475	.8513	.8553	.8594	.8635	.8676	.8718	.8760	.8803	.8846	.8888	.8931	.8973	.9015	.9057	.9098
65	.8241	.8278	.8316	.8355	.8395	.8436	.8478	.8521	.8564	.8608	.8653	.8697	.8742	.8787	.8832	.8877	.8922	.8967	.9011
66	.8113	.8151	.8190	.8230	.8271	.8314	.8357	.8401	.8446	.8492	.8539	.8585	.8633	.8680	.8728	.8775	.8823	.8870	.8917
67	.7980	.8018	.8058	.8099	.8142	.8186	.8230	.8276	.8323	.8370	.8419	.8468	.8517	.8567	.8617	.8667	.8717	.8768	.8817
68	.7840	.7879	.7920	.7962	.8006	.8051	.8097	.8144	.8192	.8242	.8292	.8343	.8394	.8446	.8499	.8552	.8605	.8658	.8711
69	.7694	.7734	.7776	.7819	.7863	.7909	.7956	.8005	.8055	.8105	.8157	.8210	.8264	.8318	.8373	.8428	.8484	.8540	.8596
70	.7542	.7582	.7624	.7668	.7713	.7760	.7808	.7858	.7909	.7962	.8015	.8070	.8125	.8182	.8239	.8297	.8355	.8414	.8473

Member name

Benefit estimate worksheet and examples

	Formula	Your Membership Tier — You as of / /	Your Membership Tier — You as of / /	Example: Tier 1 — Established membership before 4/2/2012	Examples: Tier 2 — Established membership on or after 4/2/2012 — With **less than** 30 years of creditable service	Examples: Tier 2 — Established membership on or after 4/2/2012 — With **30 years** or more of creditable service
Option A	Option A age factor *(see table)*	*Age*	*Age*	*Age 58* 0.018	*Age 60* 0.0145	*Age 60* 0.01625
x	Years of creditable service	x	x	x 35	x 28	x 30
	Base % of salary average	%	%	63.00%	40.60%	48.75%
+	RetirementPlus %, *if applicable**	+ %	+ %	+ *Participating* 22.00%	+ *Participating* 0.00%	+ *Participating* 14.00%
	Total % of salary average**	%	%	80.00%	40.60%	62.75%
x	Salary average *Tier 1, 3-yr; Tier 2, 5-yr*	x $	x $	x *3-yr sal avg* $75,000	x *5-yr sal avg* $70,000	x *5-yr sal avg* $70,000
	Option A annual allowance	$	$	$60,000	$28,420	$43,925
+	Veteran's benefit***	+ $	+ $	+ $300	+ $300	+ $300
	Final Option A annual allowance	$	$	**$60,300**	**$28,720**	**$44,225**
Option B	Final Option A annual allowance	$	$	$60,000	$28,420	$43,925
x	99% *(1% less than Option A)****	x 99%	x 99%	x 99%	x 99%	x 99%
	Option B annual allowance	$	$	$59,400	$28,136	$43,486
+	Veteran's benefit***	+ $	+ $	+ $300	+ $300	+ $300
	Option B annual allowance	$	$	**$59,700**	**$28,436**	**$43,786**
Option C	Option A annual allowance	$	$	$60,000	$28,420	$43,925
x	Option C Factor *(see table)*	x	x	x *Ben. age 57* 0.9194	x *Ben. age 59* 0.9099	x *Ben. age 59* 0.9099
	Option C annual allowance	$	$	$55,164	$25,859	$39,967
+	Veteran's benefit***	+ $	+ $	+ $300	+ $300	+ $300
	Final Option C annual allowance	$	$	**$55,464**	**$26,159**	**$40,267**
x	2/3 *(survivor portion)*	x 2/3	x 2/3	x 2/3	x 2/3	x 2/3
	Annual member-survivor benefit	$	$	**$36,976**	**$17,439**	**$26,845**

* If you are participating in RetirementPlus, and you have 30 or more years of creditable service—at least 20 of which are "membership" service with the MTRS or the Boston Retirement System as a teacher—enter the appropriate percentage from the RetirementPlus percentage table.

** Your "Total % of salary average" may not exceed 80 percent.

*** If you are a wartime veteran, $15 for each year of teaching service (up to a maximum of $300) is added to the Option A annual allowance.

**** The Option B allowance is approximately 1% less than the Option A amount. For purposes of illustration only, we have estimated the Option B amount at 1% less than the Option A amount. However, the older you are at retirement, the higher the reduction percentage will be.

Member name _____

SECTION 1

APPLICANT DATA

- Type of disability retirement applied for . . . . . ☐ Accidental ☐ Ordinary ☐ Both
- Social Security number, XXX-XX-XXXX . . . . . _____

  Member number . . . . . _____

All marriage certificate(s) and/or proof of name change(s) since birth record *(photocopy OK)*

- Gender. . . . . ☐ Male ☐ Female
- Name _____
  Prefix, if any First Middle Last Suffix, if any

  Former/maiden name, if applicable . . . . . _____

Birth certificate *(must be certified; photocopy not accepted)*

- Date of birth , mm/dd/yyyy . . . . . _____
- Mailing address _____
  Number and street Apt.

  _____
  City State ZIP

  Home phone (_____) _____ E-mail_____

- Marital status . . . . . ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Military discharge form DD214

- Veteran status . . . . . ☐ Nonveteran ☐ Veteran

  Dates of active military service: mm/yyyy

  From _____ to _____

  Total year(s) _____
- MTRS RetirementPlus status. . . . . ☐ Nonparticipating ☐ Don't know
  ☐ Participating (elected in)
  ☐ Participating (mandated)
- **Alternate address**: If you will be residing at an address other than the one above (for example, a summer or retirement address) within the next 12 months, please list below.

  Alternate address _____
  Number and street Apt.

  _____
  City State ZIP mm/yyyy mm/yyyy

  Phone (_____)_____ Dates here: From_____ to _____

SECTION 2

ATTORNEY DATA

If applicable

If you are represented by an attorney in this disability retirement application process, please provide the following information so that we may contact him or her as necessary.

- Name _____
  Prefix, if any First MI Last Suffix, if any
- Firm _____
- Address _____
  Number and street Suite/Floor

  _____
  City State ZIP
- Phone (_____)_____ Fax (_____) _____

SECTION 3

APPLICANT'S STATEMENT

■ I , _____, hereby make application for disability retirement benefits pursuant to Massachusetts General Laws, c. 32, sections 6 or 7.

The incapacity described is not the result of serious or willful misconduct on my part.

If I am applying for accidental disability benefits, I state that the incapacity described herein and in the written materials accompanying this application, was sustained as a result of an injury or hazard that I underwent as a result of my employment and while in the performance of my duties.

I do hereby certify that this statement, together with the statements made herein and on the written materials accompanying this application, are made under the pains and penalties of perjury and are true and accurate to the best of my knowledge and belief. I acknowledge that this application is made subject to Chapter 32 of the Massachusetts General Laws and titles 807 and 840 of the Code of Massachusetts Regulations. In addition, I certify that I have not been charged, or indicted, or convicted of a crime involving laws applicable to my position pursuant to M.G.L. c.32 §15.

Applicant's Signature_____ Date_____

SECTION 4

EMPLOYMENT HISTORY

■ **Current position** (position you are retiring from)

Title_____

School district _____ Grade(s) taught _____

Dates employed From_____ (mm/yyyy) to _____ (mm/yyyy) Date when you last worked_____

School_____

Phone (_____) _____ Fax (_____) _____

Name of superintendent_____ Phone (_____) _____

Name of principal _____ Phone (_____) _____

Name of immediate supervisor _____ Phone (_____) _____

■ **Creditable service estimate**

Please indicate your approximate number of years of creditable service . . . . . _____

SECTION 4 *(continued)*

EMPLOYMENT HISTORY

■ All Previous Employment

Please list all previous employment in chronological order, beginning with your oldest position and ending with your current position. If you have ever been employed by any other Massachusetts state governmental agency or unit, you may be eligible to purchase creditable service for that employment. If you list the Commonwealth of Massachusetts as a previous employer, please check the box in the last column (MA public service).

Period of employment From (mm/dd/yyyy)	To (mm/dd/yyyy)	Employer's name/ address	If MA public service, please ✓ box
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐

SECTION 5

PRIMARY TREATING PHYSICIAN

Please identify the physician who has provided you with primary care in connection with your disability. **You must contact this physician to notify him or her that the MTRS requires that he or she complete the Physician's Statement included herein (pages 21-26), and provide him or her with these pages.** Your physician then must complete the statement, and you must submit it to the MTRS with your disability retirement application.

Note: If you are applying for disability retirement based on more than one condition, you must list one primary physician for each condition. If this applies to you, please check the box, below, and attach a separate sheet.

☐ Primary treating physician's name _____
Last First Middle

Address _____
Number and street City State ZIP

Phone (_____) _____

☐ **Additional condition(s) and primary physician(s):** Please see attached sheet for additional physician listing(s).

Member name

SECTION 6

DISABILITY AND DUTIES

- Please state the medical reason which is the cause of your application for disability.

_____

_____

_____

- Please describe the essential duties which you are required to perform in your current position.

_____

_____

_____

- How frequently are you required to perform the essential duties you described above?

_____

_____

_____

- Please describe the essential duties which you are unable to perform as a result of your disability.

_____

_____

_____

SECTION 7

RECENT PHYSICAL ACTIVITIES

- For the period of the last year, please describe your physical activities, including:

Medical rehabilitation activities _____

_____

Other employment activities since the onset of your disability _____

_____

Sports activities _____

_____

Activities of daily living (for example, driving, cleaning, etc.) _____

_____

_____

SECTION 8

WORKER'S COMPENSATION

We advise that you read this section carefully. It concerns the right of the MTRS to offset your disability retirement pension benefit by the amount of certain outside payments you may receive for the same injury.

Pursuant to Massachusetts General Laws, chapter 32, s. 14(2), the MTRS has the authority to offset from your disability pension the following payments you may receive as a result of the same injury for which you receive a disability pension:

- Any and all Workers' Compensation disability payments which you receive under Massachusetts General Laws, chapter 152, ss. 31 (survivor's benefits), 34 (temporary total), 34A (permanent and total), 34B (COLA), 35 (temporary partial) and 35A (dependent's benefits).
- Any recovery for lost wages you may receive from a third party other than your employer.

The statute also requires that you cooperate with the MTRS both in filing for and receiving Workers' Compensation benefits and pursuing and reporting any third party payments. If you do not cooperate in this regard, the MTRS has the authority to suspend your disability pension and/or file for Workers' Compensation or other benefits on your behalf. **Please note: You are required to notify the MTRS as to any change in rate of your Workers' Compensation benefit (including, but not limited to changes in COLA) or prior to any settlement of your Workers' Compensation or third-party (i.e., personal injury) claim. Failure to do so may result in an overpayment for which you will be liable.**

- Have you **applied for** Workers' Compensation benefits? . . . . . ☐ Yes ☐ No
  - If "yes," date you applied for Workers' Compensation, mm/dd/yyyy _____
  - **If "no:"**
    - **Please be aware that you must apply for Workers' Compensation benefits.**
    - Are you applying for an accidental disability retirement?. . . . . ☐ Yes ☐ No
- Have you **received** or are you **receiving** Workers' Compensation benefits or a settlement? . . . . . ☐ Yes ☐ No
  - If "yes," please provide the following information:
    - Type of Workers' Compensation receiving or received. . . . . ☐ Weekly benefits ☐ Settlement ☑
    - Date of initial payment, mm/dd/yyyy . . . . . _____
    - Amount of payment as part of a weekly/ biweekly benefits or settlement . . . . . _____
    - Type of incapacity. . . . . ☐ Total ☐ Partial
    - Receiving Workers' Compensation COLA? . . . ☐ Yes ☐ No
      If "yes," please provide the date you first received a COLA . . . . . _____
    - Name of attorney for Workers' Compensation Insurer . . . . . _____
    - Name and phone number of the Workers' Compensation insurance adjuster/claims representative for the school district/town or, if self-insured, name and phone number of the Workers' Compensation agent for the school district/town. . . . . _____

      (_____) _____

☑ Copy of your settlement agreement

Member name _____

SECTION 9

SALARY DATA

In order for us to calculate your potential disability retirement benefits, we need information regarding your regular compensation. If you are:

- **A Tier 1 member (effective membership date prior to April 2, 2012),** please report **either** your three highest consecutive years' regular compensation **or** your last three years' regular compensation, whichever is greater.
- **A Tier 2 member (effective membership date on or after April 2, 2012),** please report **either** your five highest consecutive years' regular compensation **or** your last five years' regular compensation, whichever is greater.

Please also:

- Report your contracted salary for the year immediately before the three or five years reported.
- Submit copies of your contracts verifying your regular compensation listed here. Be sure to include payment schedules or contractual language to substantiate any earnings in excess of your regular contract rates.

	School Year From (mm/dd/yyyy)	School Year To (mm/dd/yyyy)	Regular Compensation $	
☑ Contract				☑
☑ Contract				☑
☑ Contract				☑
☑ Contract				☑
☑ Contract				☑
☑ Contract				☑

- As of the date of this application, what is your salary status? . . . . . ☐ Paid leave ☐ Sick bank ☐ Unpaid leave ☐ Workers' Compensation

- If you are a veteran, please also list your regular compensation for the last 12 months.

	School Year From (mm/dd/yyyy)	School Year To (mm/dd/yyyy)	Regular Compensation $	
☑ Contract				☑
☑ Contract				☑

SECTION 10

DEPENDENT CHILD DATA

Please record the names, birth dates and Social Security numbers of your children who are:

- under age 18;
- over age 18 and physically or mentally incapacitated from earning; and
- over age 18 and under 22 who are full-time students.

Name (first MI last)	Gender	Date of birth (mm/dd/yyyy)	Social Security number	Status *(check one)* Under 18	Incapacitated over 18	Student 18–22
	☐ M ☐ F					
	☐ M ☐ F					
	☐ M ☐ F					
	☐ M ☐ F					

Member name

SECTION 11

YOUR RETIREMENT OPTION SELECTION, STATEMENT AND SIGNATURE

IMPORTANT NOTE

If you have ever been **divorced**, and you have a qualified Domestic Relations Order (DRO), and the terms of your DRO specify the retirement option that you must choose, please be sure to complete this section in accordance with your DRO.

- ☐ Complete Option A month-of-death payment recipient designation (Section 13 on page 9 of this application)
- ☐ Complete Option B beneficiary designation (Section 14 on page 9 of this application)
- ☐ Option C beneficiary's birth certificate (**must** *be submitted, and* **must** *be certified; photocopy not accepted)*
- ☐ Marriage certificate(s) *(photocopy OK)*

Please select your retirement Option and provide the required information. Note:

- Be sure that you have reviewed the information on our website or on page v of this application regarding the benefits provided by each of the three available retirement options. **Please estimate your benefits using page ii–vi of this application before you finalize your option selection.**
- Once you have filed this application, you cannot change your retirement option. Because of this fact, it is important that you understand the retirement options that are available to you and that you make an informed decision based on your financial needs and the financial needs of your family.
- Please mark your option choice below. Your retirement application is not complete until the MTRS receives this completed section.
- If you have any questions, please contact our office.

I, the undersigned, having applied for retirement from the Massachusetts Teachers' Retirement System, hereby elect to receive my retirement allowance under the option selected below **(check one):**

☐ **Option A**

Option A provides the maximum benefit allowance amount, and no survivor benefits. All monthly payments cease upon your death and no benefits will be provided for any survivors. If, after your death, any benefits that you earned in the month of your death are due, they will be paid in a lump sum to the month-of-death payment recipient(s) that **you should designate by completing Section 13 on page 9 of this application.**

☐ **Option B**

Option B provides a benefit allowance that is approximately 1 percent less than the Option A allowance. Upon the member's death, it also provides for the lump-sum payment of the remainder of the member's annuity savings account, if any, to the named beneficiary or beneficiaries; in most cases, the member's annuity account will be depleted 9 to 11 years after his or her date of retirement. You may change your beneficiary designation at any time during your retirement by completing and submitting a new, revised *Beneficiary Form—Retired Member/Option B* to the MTRS. **If you select Option B, you must designate your Option B beneficiary(ies) by completing Section 14 on page 9 of this application.**

☐ **Option C**

Option C provides a benefit allowance that is generally 9 to 11 percent less than the Option A allowance. Upon the member's death, it also provides a monthly survivor benefit to one named beneficiary that is equal to 2/3 of the retiree's monthly benefit at the time of death. If you are selecting Option C, you **must** designate your Option C beneficiary here:

- Name of Option C beneficiary. First M. Last .
- Beneficiary's date of birth . . . mm/dd/yyyy . SSN
- Relationship to you . . . . . ☐ Parent ☐ Sibling ☐ Child ☐ Spouse ☐ Former spouse who has not remarried

You may **not** change your Option C beneficiary designation after your effective date of retirement. In the event that your Option C beneficiary predeceases you, contact the MTRS so that we may adjust your benefit to the higher, Option A "pop-up" amount.

I have selected the option checked above and understand that I cannot change my option selection after filing this application. Additionally, I understand that regardless of when I receive my *Notice of Estimated Retirement Benefit (NERB)*, **I cannot change my option selection after filing this application. I understand that I must file my option selection making the best estimate I can using the tools that the MTRS has provided, including those provided with this application. I also understand that I may contact the MTRS with questions.**

Applicant's signature ✕ Date

Name (please print) SSN

NOTE: Even if you do not expect to be married on your intended date of retirement, you MUST also complete Section 12, Spousal acknowledgment.

Member name

SECTION 12

SPOUSAL ACKNOWLEDGMENT

You **MUST** complete Section a, below, and then, if applicable, your spouse must complete section b. If your spouse's whereabouts are unknown, you must complete a notarized affidavit (available upon request from the MTRS's main office), including your spouse's last known address.

a) I, the undersigned, having applied for retirement from the Massachusetts Teachers' Retirement System, have elected to receive my retirement allowance under the option selected in the previous section. I hereby certify that *(check all that apply)*:

☐ I am now married or expect to be married as of my intended date of retirement as stated in this application. *Please sign and date this section, then give this form to your spouse for completion of section b.*

☐ I have been divorced and it is my understanding that there ☐ is ☐ is not ☐ don't know a Domestic Relations Order on file with the MTRS. *Please sign and date this section, then return your entire application to the MTRS.*

☐ I am NOT currently married and do not expect to be married as of my intended date of retirement as stated in this application. *Please sign and date this section, then return your entire application to the MTRS.*

I subscribe under the penalties of perjury that the above information is true, complete and correct to the best of my knowledge.

Applicant's signature ✕ Date*

Name (please print) SSN

b) As the spouse of a member who is retiring from the MTRS, you are entitled to both notification and explanation of the retirement option selected by the member. You must sign Section b before one witness; **the member named in Section a, above, cannot be your witness.** The witness must sign and date the form on the same day that you do; it is not necessary that your witness be a Notary Public.

Before completing this section, please see which retirement option your spouse has chosen in the previous section, and then read the explanations of the available retirement options as provided on pages v and vi of this application and on our website at mass.gov/mtrs. **Please be sure that you have read and understand the various provisions of the option selected by your spouse, specifically, the benefits to which you may or may not be entitled to upon his or her death. If you have any questions, do not hesitate to contact the MTRS for an explanation.**

If you fail to sign this Spousal acknowledgment, the MTRS will notify you within fifteen (15) days by registered mail of the option selected by your spouse and your right to sign and return the spousal acknowledgment within thirty (30) days. Failure to sign and return the Spousal Acknowledgment to the Massachusetts Teachers' Retirement System within 30 days will result in your spouse's selection becoming effective without your signature.

I, the undersigned, am the spouse of the member named in Section a, above, who has applied for retirement from the Massachusetts Teachers' Retirement System. I hereby certify under the penalties of perjury that:

- I have read and understand the information on Options A, B and C, and
- I am aware of the option selected by the applicant and understand the provisions of that option.

Spouse's signature ✕ Date*

Name (please print) SSN

WITNESS TO SPOUSE SIGNATURE (must be witnessed by someone **other** than the member)

I subscribe under the penalties of perjury that the member's spouse (the person named immediately above) personally appeared before me and signed this form in my presence.

Witness's signature ✕ Date*

Name (please print)

Address . . . . . .

NOTE:

ALL applicants must sign and complete this section!

* This section must be completed and signed **ON OR AFTER** the date that the member completed and signed Part 1, Section 11 (page 7).

If your spouse and/or witness sign this section **before** the date that the member signed Part 1, Section 11, we will return the application to the member to have this page completed and signed again.

 Member name

SECTION 13 — You should complete this section if you have selected **Option A** only.

OPTION A MONTH-OF-DEATH PAYMENT RECIPIENT(S)

Option A provides no survivor benefits. However, after your death, if any benefits that you earned in the month of your death have not been paid out, they will be paid in a lump sum to your month-of-death payment recipient(s). Please name the designee(s) to receive the lump-sum payment of any benefits that you earn in the month of your death below. *Please see the shaded box at bottom of this page for additional information.*

Type *(check one)* | **SSN or tax ID** | **% of payment**

☐ Person
Date of birth.
Relationship to you. . . . . .
☐ Trust or organization
Name
Address
%

☐ Person
Date of birth.
Relationship to you. . . . . .
☐ Trust or organization
Name
Address
%

Total sum of percentages listed for all PRIMARY Option A month-of-death payment recipients must equal 100%

SECTION 14 — You must complete this section if you have selected **Option B** only.

OPTION B BENEFICIARY DESIGNATION

Option B provides a benefit allowance that is approximately 1 percent less than the Option A allowance. Upon your death, it also provides for the lump-sum payment of the remainder of the member's annuity savings account, if any, to the named beneficiary(ies); in most cases, the member's annuity savings account will be depleted within 9 to 11 years after his or her retirement date. *Please see the shaded box at bottom of this page for additional information.*

Type *(check one)* | **SSN or tax ID** | **% of benefit**

☐ Person
Date of birth.
Relationship to you. . . . . .
☐ Trust or organization
Name
Address
%

☐ Person
Date of birth.
Relationship to you. . . . . .
☐ Trust or organization
Name
Address
%

Total sum of percentages listed for all PRIMARY Option B beneficiaries must equal 100%

Option A and B retirees ONLY: Additional information and optional contingent designee(s)

- You may change your designation at any time during your retirement; simply complete and submit a *Beneficiary Designation Form for Retirees.*
- You may name more than one person or entity. If you do name more than one **primary** designee, however, please be sure to indicate the percentage that each **primary** entity should receive (the total must equal 100%). If you fail to indicate a percentage, we will distribute the amount equally among the **primary** entities. If the total does not equal 100%, the difference will be paid to your estate.
- If you need more space to indicate additional entities, please make a photocopy of this page, complete the appropriate line(s), sign each additional sheet, and, in this box, indicate how many additional sheet(s) are attached . . . . . ☐

OPTIONAL—**CONTINGENT** DESIGNEE(S): If you wish, you may also name contingent designee(s). In the event that the primary designee(s) named above are not alive at the time of your death, any benefit amount due will be paid to your contingent designee(s). If any of your primary designees predecease you, they are replaced by a contingent designee, in the order in which you name them, below (the remaining primary beneficiaries' shares do not increase if one of them predeceases you, nor is that share equally split among the multiple contingent beneficiaries). If there is no contingent beneficiary who is presently living, that share is paid to your estate.

Type *(check one)* | **SSN or tax ID**

☐ Person
Date of birth.
Relationship to you. . . . . .
☐ Trust or organization
Name
Address

 Member name

If you are applying for retirement based on:

- **Ordinary disability only,** skip to Section 23 (Medical history) on page 15
- **Accidental disability only, or both accidental and ordinary disability,** please continue with Section 15 below

SECTION 15

REASON FOR ACCIDENTAL DISABILITY

One of the conditions for receiving approval of your application for accidental disability retirement benefits is that the Board must find that the disability is the natural and proximate result of either

- **the personal injury you sustained** (usually, one or several specific incidents) or
- **the hazard undergone** (generally, exposure to a harmful situation over a period of time).

- Please identify the reason for your disability. . . . . ☐ Personal injury sustained ☐ Hazard or exposure undergone
- Being as specific as possible, please describe either the personal injury you sustained or the hazard/exposure undergone

  - Date(s) _____

  - Specific time(s) or if hazard/exposure, length of time exposed _____

  - Location(s) _____

  - Description of incident(s) or hazard/exposure _____

- Please describe the job duties you were performing immediately prior to and during the time of the personal injury you sustained or the hazard/exposure undergone

SECTION 16

WITNESS DATA

■ Did anyone witness the incident(s) or hazard/exposure described above? . ☐ No ☐ Yes

■ If "yes," please provide the following information for each witness:

■ Name _____
Last First MI

Address _____
Number and street Apt. PO Box

_____
City State ZIP

Phone (_____)_____ Relationship to applicant _____

■ Name _____
Last First MI

Address _____
Number and street Apt. PO Box

_____
City State ZIP

Phone (_____)_____ Relationship to applicant _____

■ Name _____
Last First MI

Address _____
Number and street Apt. PO Box

_____
City State ZIP

Phone (_____)_____ Relationship to applicant _____

SECTION 17

INCIDENT REPORTS

■ Have you filed a report of the incident(s) or hazard/exposure described above with any person or agency? . . . . . ☐ No ☐ Yes

■ If "yes," please provide the following information for each person or agency.

■ Name _____
Last First MI

Agency _____

Address _____
Number and street

_____
City State ZIP

☑ Claim or incident report

Phone (_____)_____ Date report filed ☑ _____

■ Name _____
Last First MI

Agency _____

Address _____
Number and street

_____
City State ZIP

☑ Claim or incident report

Phone (_____)_____ Date report filed ☑ _____

SECTION 18

INSURANCE COVERAGE

- Do you have any insurance coverage which relates to the incident(s) or hazard/exposure described above? . . . . . ☐ No ☐ Yes
  - If "yes," please provide the following information for each policy. Additionally, please note: The MTRS requires that you sign an *Authorization for the release of insurance records*. This form is on page 17 and allows the MTRS to request copies of your insurance records from the insurers you list below for the period of the last five years.

- Agent's name _____ (Last / First / MI)
  Agency _____
  Address _____ (Number and street)
  _____ (City / State / ZIP)
  Phone (_____) _____ Type of coverage _____

- Agent's name _____ (Last / First / MI)
  Agency _____
  Address _____ (Number and street)
  _____ (City / State / ZIP)
  Phone (_____) _____ Type of coverage _____

SECTION 19

EMERGENCY MEDICAL TREATMENT

- Did you receive emergency medical treatment as a result of the incident(s) or hazard/exposure described above? . . . . . ☐ No ☐ Yes
  - If "yes," please provide the following information for each physician from whom you received treatment. Additionally, please note: The MTRS requires that you sign an authorization for the release of protected health records. This form is on page 18 and allows the MTRS to request copies of your medical records from the facilities and physicians you list below.

- Treating physician's name _____ (Last / First / MI)
  Hospital/facility _____
  Address _____ (Number and street)
  _____ (City / State / ZIP)
  Phone (_____) _____ Date(s) of treatment _____

- Treating physician's name _____ (Last / First / MI)
  Hospital/facility _____
  Address _____ (Number and street)
  _____ (City / State / ZIP)
  Phone (_____) _____ Date(s) of treatment _____

 Member name _____

SECTION 20

MEDICAL TREATMENT

- Have you received any medical treatment as a result of the incident(s) or hazard/exposure described above? . . . . . ☐ No ☐ Yes
  - If "yes," please provide the following information. Additionally, please note: The MTRS requires that you sign an authorization for the release of protected health records. This form is on page 18 and allows the MTRS to request copies of your medical records from the facilities and physicians you list below.

- Primary care physician's name _____
  Last First MI

  Address _____
  Number and street City State ZIP

  Phone (_____) _____

  Date(s) of treatment _____

  Nature of treatment _____

  _____

  _____

  _____

- Primary care physician's name _____
  Last First MI

  Address _____
  Number and street City State ZIP

  Phone (_____) _____

  Date(s) of treatment _____

  Nature of treatment _____

  _____

  _____

- Did you take any time off from your employment? . . . . . ☐ No ☐ Yes
  - If "yes," please list date(s) and time(s) _____

    _____

- Did your physician(s) recommend any rehabilitation? . . . . . ☐ No ☐ Yes
  - If "yes," please describe any rehabilitation you have undergone _____

    _____

 Member name

SECTION 21

OTHER ACTIONS TAKEN

- As a result of the incident(s) or hazard/exposure described above, did you file a grievance pursuant to your collective bargaining agreement? . . . . . ☐ Not applicable ☐ No ☐ Yes
  - If "yes," please describe the status of your grievance _____

_____

- As a result of the incident(s) or hazard/exposure described above, was any administrative or disciplinary action taken by your employer? . . . ☐ No ☐ Yes
  - If "yes," please explain _____

_____

_____

- As a result of the incident(s) or hazard/exposure described above, did your employer conduct any tests or studies on any area of the school building or grounds or make any repairs in such areas? . . . . . ☐ Not applicable ☐ No ☐ Yes
  - If "yes," please explain _____

_____

_____

SECTION 22

OTHER CONDITIONS

- **Contributing conditions or events**

Please describe any other circumstances, events or physical conditions that contributed or may have contributed to your disability.

_____

_____

_____

SECTION 23

MEDICAL HISTORY

The following sections relate to **any** medical treatment you have received.

■ Prior illnesses, accidents or injuries

Please list **all** prior illnesses, accidents or injuries you have had, beginning with the oldest occurrence and ending with the most recent one.

Date(s) From (mm/dd/yyy)	To (mm/dd/yyy)	Description of illness, accident or injury	Medical treatment received

■ Hospitals, medical facilities or institutions

Please list all hospitals, medical facilities or institutions which you have consulted or at which you received any treatment, beginning with the oldest occurrence and ending with the most recent one. Additionally, please note: The MTRS requires that you sign an authorization for the release of protected health records. This form is on page 18 and allows the MTRS to request copies of your medical records from the facilities you list below.

Date(s) From (mm/dd/yyy)	To (mm/dd/yyy)	Name of facility/ Address/ Phone number	Reason for visit

SECTION 23 *(continued)*

MEDICAL HISTORY

■ Physicians

Please list all physicians whom you have consulted or from whom you received any treatment, beginning with the oldest consultation and ending with the most recent one. Additionally, please note: The MTRS requires that you sign an authorization for the release of protected health records. This form is on page 18 and allows the MTRS to request copies of your medical records from the physicians you list below.

Date(s) From (mm/dd/yyyy)	Date(s) To (mm/dd/yyyy)	Name of physician/ Address/ Phone number	Reason for consultation
_____	_____	_____	_____
		_____	_____
		_____	_____
_____	_____	_____	_____
		_____	_____
		_____	_____
_____	_____	_____	_____
		_____	_____
		_____	_____

SECTION 24

PAID AND UNPAID LEAVES

As a result of time away from your employment, if any, because of your disability, have you

- taken any paid sick leave?. . . . . ☐ No ☐ Yes; from _____ to _____
- taken any paid vacation time? . . ☐ No ☐ Yes; from _____ to _____
- taken any unpaid sick leave?. . . . ☐ No ☐ Yes; from _____ to _____
- taken any unpaid leave? . . . . . ☐ No ☐ Yes; from _____ to _____

 Member name

MTRS
MASSACHUSETTS TEACHERS' RETIREMENT SYSTEM

Main Office
500 Rutherford Avenue, Suite 210
Charlestown, MA 02129-1628
Phone 617-679-MTRS (6877)
Fax 617-679-1661
Online mass.gov/mtrs

Applicant's authorization for release of

Insurance Records

SECTION 1

APPLICANT'S STATEMENT AND AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS

To be completed by the applicant

■ Re: _____
Name of applicant/record subject

_____
Number/street

_____
City State ZIP

_____ _____
Social Security number Date of birth

■ I authorize the MTRS to submit this release to, and to request my insurance records from, any insurer or agency I have listed in this Disability Retirement Application.

Additionally, I understand that if the insurer or agency charges any fee for providing these records, I will be responsible for the payment of such fee. If I do not agree to pay, I understand that my application may not be processed.

I authorize the below-named individual, insurer or agency to release to the Massachusetts Teachers' Retirement System any and all information, reports and records it may have regarding any application or claim for insurance I have made during the five (5) years preceding the date beside my signature, below. The scope of this authorization includes the release and copying of such information, reports and records, including but not limited to: correspondence, application forms, claim forms and medical examinations. A photocopy of this document, including my signature, shall be as valid and effective as the original.

■ Signature_____ Date_____

SECTION 2

REQUEST FOR INSURANCE RECORDS

To be completed by the MTRS

■ **Keeper of the Records**

_____
Name of insurer and/or agency

_____
Number/street

_____
City State ZIP

_____ _____
Name of record subject's employer/group Policy/certificate number

■ Date of request _____

■ Please forward records by_____

■ **To the Keeper of the Records:** You have been named as having provided insurance coverage by the above-noted individual in his or her application for disability retirement. In accordance with the above authorization, please submit your insurance records regarding this individual, by the forwarding date indicated, directly to:

Disability Case Manager
Massachusetts Teachers' Retirement System
500 Rutherford Ave., Suite 210
Charlestown, MA 02129-1628

Please include a copy of this sheet with any records that you send us. If you have any questions, please contact the Disability Case Manager immediately at 617-679-6877. Thank you for your cooperation and assistance.

 Member name

MTRS
MASSACHUSETTS TEACHERS' RETIREMENT SYSTEM

Main Office
500 Rutherford Avenue, Suite 210
Charlestown, MA 02129-1628
Phone 617-679-MTRS (6877)
Fax 617-679-1661
Online mass.gov/mtrs

Retirement Board Authorization to
Use or Disclose Protected Health Information

SECTION 1

Please note:

- All numbered entries must be completed for this authorization to be valid.
- Please note, Retirement Boards are not covered entities under the Health Insurance Portability and Accountability Act (HIPAA), however all information is treated in a confidential manner consistent with Federal and State privacy laws.

1. I hereby authorize: _____
(physician, hospital, insurance company, employer, other health/rehabilitation entity)

to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to Federal or State law protecting its confidentiality. Information released on this authorization, if redisclosed by the recipient, is no longer protected.

2. Patient Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

3. Information to be disclosed to: Massachusetts Teachers' Retirement System
500 Rutherford Ave., Suite 210
Charlestown, MA 02129-1628

4. Please check the box below to authorize release of your complete medical record, or, use the lines below to stipulate any exceptions.

☐ Authorize Release of Complete Medical Record

Exceptions: _____

_____

5. I have checked the box below indicating the purpose for the disclosure of this information.

☐ Disability Retirement Application: (G.L. c.32, §6 & §7)

☐ Restoration to Service Evaluation (including rehabilitation): (G.L. c.32, §8)

☐ Accidental Death Benefit: (G.L. c.32, §9 & §100)

6. I understand I may revoke this authorization at any time by notifying the Retirement Board in writing, unless action has already been taken in reliance upon it, or during an appeal under the applicable law.

7. This authorization will expire upon final determination of my disability application or Comprehensive Medical Evaluation/Rehabilitation/Restoration to Service process or up to one year from date signed below.

8. _____
Signature of Patient or Legal Representative

10. _____
Date

9. _____
Printed Name of Patient or Patient's Representative

_____
Relationship to Patient/Authority to Act for Patient if applicable

 Member name

MTRS
MASSACHUSETTS TEACHERS' RETIREMENT SYSTEM

Main Office
500 Rutherford Avenue, Suite 210
Charlestown, MA 02129-1628
Phone 617-679-MTRS (6877)
Fax 617-679-1661
Online mass.gov/mtrs

Applicant's authorization for release of

Tax Records

SECTION 1

APPLICANT'S STATEMENT AND AUTHORIZATION FOR RELEASE OF TAX RECORDS

To be completed by the applicant

■ Re:_____
Name of applicant/record subject

_____
Number/street

_____
City State ZIP

_____ _____
Social Security number Date of birth

■ I understand that I am obliged to authorize the release of my tax records from the Federal Internal Revenue Service and/or the Massachusetts Department of Revenue. Additionally, I understand that if my application for disability retirement is approved by the MTRS, I will be required to authorize annual releases of my tax records to the MTRS by signing any release form(s) as required (IRS form 4506 and Public Employee Retirement Administration form WM 394). I also understand that my failure to provide such future authorizations may result in the suspension and/or termination of my disability benefits.

■ Signature_____ Date_____

 Member name _____

MTRS
MASSACHUSETTS TEACHERS' RETIREMENT SYSTEM

Main Office
500 Rutherford Avenue, Suite 210
Charlestown, MA 02129-1628
Phone 617-679-MTRS (6877)
Fax 617-679-1661
Online mass.gov/mtrs

Disability applicant's Medical Panel selection form

SECTION 1

INSTRUCTIONS TO APPLICANT

All applicants for disability retirement must complete this form. And, unless the MTRS denies your application as a result of an initial fact-finding hearing, you must have a medical panel examination. The Public Employee Retirement Administration Commission (PERAC) appoints all medical panels. No member can receive a disability retirement unless the medical panel certifies to the MTRS that the member is disabled, that the member's disability is likely to be permanent and, in the case of an accidental disability application, that the member's disability is causally related to employment. (If the acceleration of a pre-existing condition is as a result of an accident or hazard undergone in the performance of the member's duties, causation would be established.)

If and when your case is at this stage, we will request that PERAC convene a medical panel, taking into consideration the nature of disability claimed, the type of doctors you have recently seen and where you live. PERAC pays the fees of the physicians on the medical panel. The medical panel will consist of three doctors; by law, the physicians cannot be members in an associated practice. Prior to the examination, we will forward copies of your medical records to each of the physicians for their review.

You have the choice of having the three physicians appointed to the medical panel examine you

- as a group, regional medical panel (in one examination at one place at one appointment time) **OR**
- individually (in three separate examinations, potentially at three different locations at three different times).

By way of this form, you are selecting the type of medical panel examination you want. The statute requires that medical panel examinations take place as soon as possible at a time and place that is convenient for all parties. If you select a group panel and the panel fails to meet within 60 days of its appointment by PERAC, then PERAC will automatically schedule three separate examinations. You can amend your selection at any time during the 60 days after the panel has been appointed.

Please complete the Applicant Data and Medical Panel Selection sections, below.

SECTION 2

APPLICANT DATA

- Type of disability retirement applied for. . . . . ☐ Accidental ☐ Ordinary ☐ Both Accidental and Ordinary

- Name _____
  Last First Middle

  Current Address _____
  Number and street Apt. PO Box

  _____
  City State ZIP

  Phone (_____)_____ SSN _____

SECTION 3

MEDICAL PANEL SELECTION

- I, the undersigned, having applied for disability retirement from the Massachusetts Teachers' Retirement System, understand that in order to receive approval of my application, I must be examined by a three-physician medical panel appointed by the Commissioner of the Public Employee Retirement Administration Commission. I hereby select the following type of medical panel (check one):

  ☐ **A regional medical panel** (group exam) ☐ **Separate appointments** (individual exams)

- I understand that:
  - If I do not select a type of medical panel, a group panel will automatically be assigned to examine me.
  - If I fail to appear at any of the scheduled medical appointments, my application may be denied by the MTRS.
  - If I am unable to attend a scheduled medical appointment, I must give the Commissioner of PERAC reasonable notice, and if I do not provide reasonable notice to PERAC, I may be responsible for payment for the appointment. I may request that the appointment be rescheduled, but I understand that the Commissioner ordinarily only reschedules appointments as a result of extenuating circumstances such as death in the member's family or hospitalization of the member. If the Commissioner denies my request for rescheduling and I fail to appear at the originally scheduled appointment, the MTRS may deny my application and notify me and all parties of its decision and appeal rights.
  - If I select a regional medical panel and the panel fails to meet within 60 days of its appointment, PERAC will schedule separate appointments with three physicians.
  - I may change the type of medical panel I have selected within 60 days of its appointment by PERAC; to do this, I must submit an amended Medical Panel Selection Form (available upon request) to the MTRS.

Applicant's signature _____ Date _____

Member name

☐ Accidental ☐ Ordinary ☐ Both

Please have **pages 21–26** completed by the physician who provided primary treatment in connection with your disability, then returned to you. These pages must then be submitted to the MTRS with your disability retirement application. Your disability retirement application is not complete without your physician's statement.

MASSACHUSETTS TEACHERS' RETIREMENT SYSTEM

Disability Applicant's Physician's Statement

Note to physician:
This statement must be returned to the applicant once completed.

- **Who should complete this Statement?**
  In accordance with 840 CMR 10.06(1)(b), this Statement must be prepared by the licensed medical doctor who has furnished primary treatment in connection with the applicant's disability.

- **Why are we asking you to complete this Statement?**
  In the disability retirement application the applicant submitted to the Massachusetts Teachers' Retirement System, the applicant has identified you as the physician who has provided the primary care and treatment for his or her disability.
  There are two types of disability retirement:
  - **accidental**: an individual is asserting that his or her disability is the result of a job-related incident or injury or hazard undergone.
  - **ordinary**: an individual is **not** asserting that his or her disability is the result of a job-related incident or injury or hazard undergone.

  Depending on the type of disability retirement the individual has applied for, you are asked to consider specific questions and to submit a written report that supports the medical basis for your conclusions.

- **Are there key standards or guidelines that you should consider when completing this Statement?**
  Yes, please review the definitions contained herein (page 26) of *Accidental Disability, Aggravation of a Pre-Existing Condition, Ordinary Disability, Permanency Standard* and *Risk of Re-injury*.

- **Whom should you contact if you have questions about this Statement?**
  If you have any questions or need clarification, please contact our Disability Case Manager at 617-679-6106.

- **What is the process associated with this Statement?**
  The applicant's disability retirement application will not be considered complete until this completed Statement has been received by the MTRS. Delays in filing any of the required materials will impede timely processing of the application. You need to:
  - ☐ **Complete** all sections of this Statement and attach any documentation that may further substantiate your conclusions. Please note that you may provide the requested information by writing your responses in the space provided in this Statement, or by submitting a narrative report using the items listed as your template.
  - ☐ **Make a copy** of your completed Statement, and any attachments, for your files.
  - ☐ **Return** the completed original Statement, and any attachments, to the disability applicant named at the top of this page. The applicant must submit your statement with his or her completed application.

MAIN OFFICE

500 Rutherford Ave., Suite 210
Charlestown, MA 02129-1628
Phone 617-679-MTRS (6877)
Fax 617-679-1661

ONLINE

mass.gov/mtrs

MTRS
MASSACHUSETTS TEACHERS' RETIREMENT SYSTEM

Member name _____

☐ Accidental ☐ Ordinary ☐ Both

SECTION 1

APPLICANT

- Applicant's name _____ SSN _____
- Type of disability applied for . . . . . ☐ Accidental ☐ Ordinary ☐ Both

SECTION 2

PRIMARY TREATING PHYSICIAN

- Name _____
  Last First Middle

  Specialization _____

  Address _____
  Number and street Suite/floor

  _____
  City State ZIP

  Phone (_____) _____ Fax (_____) _____

  E-mail _____

- Are you certified to practice medicine? ☐ No ☐ Yes, in the following state(s): _____

- Regarding your medical license, please provide the following information:

  License number . . . . . _____

  Issued by (state). . . . . _____

  Date issued . . . . . _____

- Have you provided the applicant with professional care with respect to his or her current disability? . . . . . ☐ No ☐ Yes, since (month/year): _____

- Have you provided the applicant with professional care with respect to other medical reasons not connected to or her current disability? . . . . . ☐ No ☐ Yes, since (month/year): _____

- If the type of disability applied for is accidental disability, please state the date of injury. . . . . ☐ N/A ☐ Date: _____

Member name

☐ Accidental ☐ Ordinary ☐ Both

SECTION 3

PHYSICIAN'S CERTIFICATION OF APPLICANT'S DISABILITY STATUS

Question 1 (must be answered for all applicants):

Is the applicant mentally or physically incapable of performing the essential duties of his or her particular job? . . . . . ☐ **Yes** ☐ **No**

- Applicant's date(s) of injury(ies) or exposure(s):

- Applicant's job title: _____

- Job duties were reviewed? . . . . . ☐ Yes ☐ No

- Applicant able to perform essential duties? . . . . . ☐ Yes ☐ No

If no, when was the applicant last able to perform essential duties? _____

Which essential duties cannot be performed by the applicant (restrictions)?

Member name

☐ Accidental ☐ Ordinary ☐ Both

SECTION 4 *(continued)*

PHYSICIAN'S CERTIFICATION OF APPLICANT'S DISABILITY STATUS

Question 2 (must be answered for all applicants):

Is the condition for which the applicant seeks disability retirement likely to be permanent (please refer to *permanency standard*, page 26)? . . . ☐ **Yes** ☐ **No**

- What are the applicant's medical diagnoses?

- Please list key test or imaging or other data confirming diagnoses:

- Has the condition(s) changed over time? . . . . . ☐ Yes ☐ No

  If in the past 3 months, please describe

  If in the past year, please describe

- Non-surgical therapeutic interventions and outcomes:

  Medications: _____

  Chiropractic: _____

  Other: _____

- Surgical interventions and outcomes:

Type of surgery	Date	Outcome

- Your assessment of anticipated natural course of the diagnoses?

  ☐ Stable or plateau ☐ Likely to regress ☐ Likely to resolve

- Has Maximum Medical Improvement (MMI) been reached? . . . . . ☐ Yes ☐ No

- If you think the applicant's disability will continue indefinitely, please state why:

Member name

☐ Accidental ☐ Ordinary ☐ Both

SECTION 4 *(continued)*

PHYSICIAN'S CERTIFICATION OF APPLICANT'S DISABILITY STATUS

Question 3 (must be answered for accidental disability applicants):

Is said incapacity such as might be the natural and proximate result of the claimed personal injury sustained or hazard undergone in the performance of the applicant's duties and on account of which this disability retirement is based? . . . . . ☐ **Yes** ☐ **No**

- Describe the event(s) or onset of condition(s) that in your opinion led to applicant's disability:

- What other life event/circumstance/condition in the applicant's medical history may have contributed to or resulted in the disability claimed?

- Upon weighing the medical influence described, is it more likely that the disability was caused by the job-related personal injury or hazard undergone, or the non-work related event or circumstance or condition?

SECTION 5

PHYSICIAN'S STATEMENT AND SIGNATURE

- I, the undersigned physician, understand that the above-named applicant is a member of the Massachusetts Teachers' Retirement System who has applied for disability retirement pursuant to the provisions of Massachusetts General Laws, Chapter 32. I have conducted a physical examination and have knowledge of the pertinent facts of his/her case as described. I certify that I have read and understand the information contained in this statement, and I subscribe, under the penalties of perjury, that the information I have supplied in this Statement and in my attached medical reports (if applicable) is true, complete and correct to the best of my knowledge.

Physician's name (please print) _____

Physician's signature _____ Date _____

Member name

☐ Accidental ☐ Ordinary ☐ Both

SECTION 6

DEFINITIONS

Accidental Disability

In an application for Accidental Disability Retirement, an applicant asserts that his or her disability is the result of a job-related incident or injury. For such applications, your responses to Questions 1, 2 and 3 are required.

Aggravation of a Pre-Existing Condition

You may find that a previous condition or injury is related to the condition or injury that is the basis of the disability application. If the acceleration of a pre-existing condition or injury is as a result of an accident or hazard undergone, in performance of the applicant's duties, causation would be established. However, if the disability is due to the natural progression of the pre-existing condition or was not aggravated by the alleged injury sustained or hazard undergone, causation would not be established.

Ordinary Disability

In an application for Ordinary Disability Retirement, an applicant does not assert that his or her disability is the result of a job-related incident or injury. For such applications, your response to Questions 3 is not necessary. But please note that you may also respond to Question 3 if your determination is that consideration of causality is appropriate even though the applicant has not applied for accidental disability retirement.

Permanency Standard

A disability is permanent if it will continue for an indefinite period of time that is likely to never end even though recovery at some remote, unknown time is possible. If you are unable to determine when the applicant will no longer be disabled, you must consider the disability to be permanent. However, if the recovery is reasonably certain after a fairly definite time, the disability cannot be classified as permanent. It is imperative that the physician makes his or her determination based on the actual examination of the applicant and other available medical tests or medical records that have been provided. It is not the physician's task to look into employment possibilities that may become available to an applicant at some future point in time.

Risk of Re-injury

The Contributory Retirement Appeal Board (CRAB) has found, "even if a member is physically capable of performing all of the essential duties of his or her positions, he or she may be disqualified if a return to work would pose an unreasonable risk to serious harm to the member or third parties." This risk of re-injury has to reasonably be expected to involve a substantial harm.