



**THIS IS A SAMPLE APPLICATION FOR  
DISABILITY RETIREMENT**

**PLEASE CONTACT THE ACERA BENEFITS  
DEPARTMENT TO REQUEST AN ACTUAL  
APPLICATION**

**SAMPLE ONLY**



# APPLICATION FOR DISABILITY RETIREMENT

Member Name: \_\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

I am applying for disability retirement because I believe I am permanently disabled from performing the duties of my assigned job. I make this application in accordance with the provisions of the "County Employees Retirement Law of 1937", the Bylaws and regulations governing the Alameda County Employees' Retirement Association (ACERA), and the ACERA Disability Retirement Procedures.

Applicant Signature: \_\_\_\_\_

Applicant Name: \_\_\_\_\_

Please type, or print in black ink.

**1. GENERAL INFORMATION.** Please provide general background information as requested below.

Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
Address: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
City & State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_  
Email address (optional): \_\_\_\_\_  
List any previous names under which you have worked: \_\_\_\_\_  
Employee I.D. No., if applicable \_\_\_\_\_

**2. APPLICATION TYPE.** (Check all that apply). Please indicate the type(s) of Disability Retirement you are applying for, as requested below.

**Non-Service Connected Disability Retirement**

Injury/Illness that was not incurred at work.

Five (5) years of service required per California Gov. Code § 31720(b).

Do you have Five (5) years of service? Yes  No  Unsure

**Service Connected Disability Retirement.**

Injury/Illness that was incurred at work. No minimum years of service required.

Do you want to be considered for a non-service connected disability if your service-connected disability is denied?

Yes  No



# APPLICATION FOR DISABILITY RETIREMENT

**3. RECIPROCITY.** When a member who has established reciprocity with ACERA and another retirement system retires on disability, under government code section 31838.5, each system is required to pay only its proportional share of the disability payment, based on the portion of the overall combined service that was earned in each system. The member may not receive a total benefit amount for more than what they would have received had all service been earned in one retirement system.

**Please check and complete all that apply:**

- I am currently an active member of ACERA and have a deferred retirement with (reciprocal agency): \_\_\_\_\_.
- I am a deferred member of ACERA and an active member of (reciprocal agency): \_\_\_\_\_.
- Reciprocity does not apply

**If you are an active member of ACERA, please continue to complete the rest of the Application. If you are a deferred member of ACERA, you may stop filling out the Application. ACERA requires verification from the reciprocal agency of your disability benefit including the type (service or non-service connected), the effective date, final average salary used, the years of service credited in the agency and your monthly benefit amount.**

**4. CURRENT STATUS. (Check all that apply)** Please check any of the following that apply to you, and answer the related question.

- Currently Receiving Retirement Benefits.** Are you currently receiving any retirement benefits? Please specify the company or employer and the type.  
\_\_\_\_\_  
\_\_\_\_\_
- Terminal Illness and Expedited Processing of Application.** Check if you are currently suffering from a terminal illness, have medical documentation regarding your status, and request expedited processing of your Disability Application.



## APPLICATION FOR DISABILITY RETIREMENT

**5. EFFECTIVE DATE.** If you are ultimately granted a disability retirement, your disability retirement allowance shall be effective as of the date your Application is filed with ACERA, or the date following your last day of compensation if that date is later than the date your Application is accepted. You may request an earlier effective date, i.e., the day following the last day for which you received regular compensation when that date is earlier than the date your Application is accepted, if you demonstrate that the filing of your Application was delayed by administrative oversight or by an inability to ascertain the permanency of your incapacity. If you are requesting an earlier effective date, you **must** provide the information noted below.

**If you are requesting an earlier effective date, you must provide the information requested:**

I request an **Earlier Effective Date**. I have attached the following information:

Medical report/ documentation stating when my injury/illness became permanent.

**OR**

No such documentation exists; I have attached documentation, which demonstrates that my injury is not yet permanent.

**AND**

Documentation regarding my last day of compensation.

I am not requesting an **Earlier Effective Date**.

**6. NOTICE RE: BUY-BACK OPTION.** Eligibility for non-service-connected disability is five years of credited service with ACERA. If you have previously withdrawn or been distributed money accumulated during prior service years, you may be able to buy back those years of service. If you must buy back service years to achieve eligibility and have service years available to buy, you must do so prior to completing this Application in order to receive credit for those previously withdrawn service years. [See Gov. Code § 31652(a).] **IMPORTANT NOTICE; READ CAREFULLY: Failure to purchase service years prior to completing this Disability Retirement Application will constitute a waiver of your rights to redeposit those contributions.**

I understand that I may buy back contributions previously withdrawn from ACERA prior to completing my Disability Retirement Application in order to receive credit for those additional service years.

I do want to buy back contributions previously withdrawn from ACERA.



# APPLICATION FOR DISABILITY RETIREMENT

**7. NOTICE OF RIGHT TO LEGAL REPRESENTATION.** You are not required to have an attorney at any time to apply for a disability retirement. However, you are entitled, at your own expense, to be represented by legal counsel at any and all stages of the disability proceedings. Should you choose to be represented by counsel, you must file a written notice of the hiring, changing or dismissing counsel with ACERA's Disability Unit. Once written notification is received by ACERA that you have legal counsel, all notices, correspondence and documents shall be sent to that attorney. Absent such written designation, ACERA is not obligated to recognize any attorney claiming to represent you. If you decide to change attorneys or no longer wish to be represented by a specific attorney, you must notify ACERA in writing.

- I understand that I have the right to be represented by legal counsel at any and all stages of the disability proceedings.
- I am not represented by legal counsel at this time. I understand that should I later choose to be represented by counsel, I must file a written notice of the hiring of counsel with ACERA's Disability Unit.
- I am represented by legal counsel. His/her contact information is listed below:

**Name:** \_\_\_\_\_ **Firm:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Telephone number:** (\_\_\_\_) \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

I understand that my attorney will receive all notices, correspondence and documents relevant to my Disability Application, however, the Disability Coordinator may contact me directly on some occasions.

- I choose to receive copies of all notices, correspondence and documents sent to my attorney.
- I choose not to receive copies of all notices, correspondence and documents sent to my attorney.

**8. CURRENT EMPLOYMENT.** Please complete the following information about your current employment.

**Department:** \_\_\_\_\_ **Immediate Supervisor:** \_\_\_\_\_

**Job Classification:** \_\_\_\_\_ **Membership Status:**  **General Member**  
 **Safety Member**

**Original Start Date of Employment :** \_\_\_\_\_ **Date assigned to most recent job classification:** \_\_\_\_\_



# APPLICATION FOR DISABILITY RETIREMENT

Since your Original Start Date of Employment, was there a time when you were not employed by this Employer or on any extended leave of absence?

Yes.  (If yes, please explain below.)      No.

\_\_\_\_\_  
\_\_\_\_\_

**9. CURRENT WORK STATUS WITH ACERA EMPLOYER.** Please check the appropriate section(s), and supply the information request.

Are you still receiving a paycheck, including sick leave or vacation time?

Yes  No

- If NO, when was the last paycheck you received? \_\_\_\_\_
- When was the last day you actually worked? \_\_\_\_\_

Please complete the following if you are **Currently Working**.

- I am currently working \_\_\_\_\_ hours per week as follows:
- Usual and Customary Work, **or**
- Modified Work. Effective Date of modified duty: \_\_\_\_\_

The modified duty is:  Temporary  Permanent

Please complete the following if you are **Currently Not Working**.

- I am currently not working, however, am still an employee in the following status:
  - Regular Sick Leave -- Approximate date leave ends: \_\_\_\_\_
  - Leave Without Pay -- Date paid compensation ended: \_\_\_\_\_
  - Leave with Pay/Admin Leave -- Reason \_\_\_\_\_
  - Labor Code Section 4850 Leave with Compensation

Effective Date: \_\_\_\_\_ Approximate date leave ends: \_\_\_\_\_



# APPLICATION FOR DISABILITY RETIREMENT

Temporary Disability (Workers' Compensation)

Effective date: \_\_\_\_\_ Approximate date leave ends: \_\_\_\_\_

Permanent Disability (Workers' Compensation)

Date deemed permanent and stationary \_\_\_\_\_

Long Term Disability

Other (Please specify): \_\_\_\_\_

Please complete the following if you are **No Longer Employed with the County or Other ACERA Participating Employer Group**:

I resigned from my employment. If so, effective date and why?

\_\_\_\_\_  
\_\_\_\_\_

I was terminated from my employment for cause, or I am in the process of being terminated.

Effective date of termination: \_\_\_\_\_.

I took a regular service retirement.

Effective date of service retirement: \_\_\_\_\_.

**10. PRESENT NON-ACERA EMPLOYMENT.** If you are presently working for an employer other than the County of Alameda (including self-employment or non-compensated work, and any other circumstances in which you may perform services for money or other compensation), please provide the following information, as requested below: (1) the name, address and telephone number of the employer; (2) the dates of employment; (3) the nature of the work.

<u>Name of Employer</u>	<u>Address &amp; Phone number of Employer</u>	<u>Date(s) of Employment</u>	<u>Nature of work</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



# APPLICATION FOR DISABILITY RETIREMENT

**11. INJURY/ ILLNESS.** A permanent disability may be the result of an injury, illness or disease. The cause may be work-related or may not be work-related. Please complete the following section for each and every injury, illness or disease which forms the basis of your Disability Application. Additional pages available upon request. If additional pages required, please check the box below and continue on a separate page(s).

\_\_\_\_\_ (#) **Additional page(s) attached.**

**11.1 Injury/Illness #1:**

Injury/Illness Type: \_\_\_\_\_

Description of Injury/Illness: \_\_\_\_\_

\_\_\_\_\_

When did you first experience the symptoms? \_\_\_\_\_

Date you first became disabled? \_\_\_\_\_

Last day worked? \_\_\_\_\_

Have there been any breaks in service, if so, when? \_\_\_\_\_

Physician(s) treating this injury/illness.

(1) Name: \_\_\_\_\_ Phone #: \_\_\_\_\_.

(2) Name: \_\_\_\_\_ Phone #: \_\_\_\_\_.

(3) Name: \_\_\_\_\_ Phone #: \_\_\_\_\_.

If you are receiving ongoing medical or therapeutic treatment pertaining to the injury, illness or disease for which you are applying, please provide the information requested below:

<b>(a) Type of Treatment/Therapy</b>	<b>(b) Name of Health Care Provider</b>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



# APPLICATION FOR DISABILITY RETIREMENT

Is your disability the result of a disease?  Yes  No.

If yes, please provide the following information:

a. A description of the disease:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. When did you first experience symptoms of the disease?

\_\_\_\_\_

c. The date the disease was first diagnosed and the name of the diagnosing physician:

\_\_\_\_\_

Is your disability the result of an injury or injuries?  Yes  No.

If yes, please provide the following information:

a. The date, time of day and place the injury occurred: \_\_\_\_\_

b. How and why the injury occurred: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

c. The name, address and telephone number of all witnesses to the injury: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you feel your employment caused or contributed to your illness/injury?

Yes\*  No

\* If yes, please describe how: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# APPLICATION FOR DISABILITY RETIREMENT

Have you ever had any similar injury, disease, symptom, complaint, disability, or other similar condition?

Yes\*

No

\* If yes, for each such prior injury or condition, please describe.

---

---

---

---

---

### 11.2 Injury/Illness #2:

Injury/Illness Type: \_\_\_\_\_

Description of Injury/Illness: \_\_\_\_\_

---

---

---

---

When did you first experience the symptoms? \_\_\_\_\_

Date you first became disabled? \_\_\_\_\_

Last day worked? \_\_\_\_\_

Have there been any breaks in service, if so, when? \_\_\_\_\_

Physician(s) treating this injury/illness:

(1) Name: \_\_\_\_\_ Phone #: \_\_\_\_\_.

(2) Name: \_\_\_\_\_ Phone #: \_\_\_\_\_.

(3) Name: \_\_\_\_\_ Phone #: \_\_\_\_\_.



# APPLICATION FOR DISABILITY RETIREMENT

If you are receiving ongoing medical or therapeutic treatment pertaining to the injury, illness and/or disease for which you are applying, please provide the information requested below:

(a) Type of Treatment/Therapy	(b) Name of Health Care Provider

Is your disability the result of a disease?  Yes  No.

If yes, please provide the following information:

a.) A description of the disease:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b.) When did you first experience the symptoms of the disease?

\_\_\_\_\_

c.) The date the disease was first diagnosed and the name of the diagnosing physician:

\_\_\_\_\_  
\_\_\_\_\_

d.) Is your disability the result an injury or injuries?  Yes  No

If yes, please provide the following information:

1. The date, time of day and place the injury(ies) occurred: \_\_\_\_\_

2. How and why the injury(ies) occurred: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



# APPLICATION FOR DISABILITY RETIREMENT

3. The name, address and telephone number of all witnesses to the injury:

\_\_\_\_\_  
\_\_\_\_\_

Do you feel your employment caused or contributed to your illness/injury?  Yes\*  No

If yes, please describe how:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had any similar injury, disease, symptom, complaint, disability, or other similar condition?

Yes\*  No

\* If yes, for each prior injury or condition, please describe.

\_\_\_\_\_  
\_\_\_\_\_

**12. PERMANENT INCAPACITY FROM PERFORMING JOB DUTIES.** To be eligible for a disability retirement, Applicant must demonstrate that he/she is permanently disabled from substantially performing the essential duty(ies) of his/her job. Please answer the questions below concerning the permanency of your claimed injury/illness.

Please describe all of the usual duties of your employment at the time you became disabled (include only those activities that you were **actually** required to perform, and **actually** did perform). *Do not substitute a job description for this answer. You may include a Description of Employee's Essential Job Functions, if available.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you believe that you are permanently disabled from performing one or more of the duties described in response to the previous question?

Yes  No

You must have documentation (a letter or other documentation from a medical provider) containing an opinion on the permanency of your condition. Please attach.

Are you scheduled for surgery for the injury/disease claimed or has any medical provider recommended surgery for your condition?

Yes  No



# APPLICATION FOR DISABILITY RETIREMENT

In your own words, please tell us what duties you can't perform as a result of your illness/injury?

---

---

---

---

What accommodation(s) do you feel could be made that would allow you to return to work?

---

---

---

Have these accommodations been discussed with your department?  Yes\*  No

\* If yes, when and what were the results?

---

---

---

---

At any time since you first became disabled, has your condition improved enough so that you would have been capable of performing your usual duties?

Yes\*  No

\* If yes, when?

---

---

---



# APPLICATION FOR DISABILITY RETIREMENT

**13. SAFETY MEMBERS' INJURY/ ILLNESS.** If you are a safety member, a firefighter member, a probation officer, or a member in active law enforcement who has completed five (5) years or more of service in ACERA or another California public pension, please answer the questions below.

- 13.1 Is this Application based on heart trouble?  Yes  No
- 13.2 Is this Application based on a disability related to any cancer?  Yes  No
- 13.3 Is this Application based on a blood-borne infectious disease?  Yes  No
- 13.4 Is this Application based on an exposure to a biochemical substance?  Yes  No

**14. ALL MEDICAL TREATMENT WITHIN THE PAST FIVE (5) YEARS.**

Were you examined or treated by any health care provider **for any reason**, within the five years immediately before the injury or disease that is the basis for your Application for Disability Retirement?

- Yes\*
- No

\* If yes, for each such provider, please state (a) name, (b) address; (c) the date(s) of the examination or treatment (*Note: a date range is sufficient; for example 08/16/94 – present, or 09/91 – 01/92*); and (d) a description of each symptom, complaint or other condition for which you were examined or treated.

(a) Health Care Provider Name	(b) Address	(c) Date(s) of examination or treatment	(d) Description of complaint, symptom, condition

Since the injury or disease that is the basis for your Application for Disability Retirement, for each health care provider that you have seen **for any reason other than routine medical services**, please state: (a) their name and address; (b) the date(s) of the examination or treatment (c) a description of each symptom, complaint or other condition for which you were examined or treated.

(a) Name of Health Care Provider	(b) Address	(c) Date(s) of examination or treatment	(d) Description of complaint, symptom, condition



# APPLICATION FOR DISABILITY RETIREMENT

## 15. OTHER CLAIMS FILED.

Please check any claim(s) you have filed related to the injury, illness and/or disease that are the basis for your Application for Disability Retirement:

- Workers' Compensation       State Disability       Social Security
- Long-Term Disability       Unemployment
- Other pending claim or legal action against employer

For each such claim or action, please give the following information:

- a. The nature of the claim or action : \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- b. The date the claim or action was filed: \_\_\_\_\_
- c. The name and address of the court, company or agency where the claim or action was filed:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**For multiple claims, please continue on a separate page.**

## 16. ADDITIONAL INFORMATION.

Please include any further information, which might aid the Board of Retirement in making a determination on your Application for Disability Retirement.

---



---



---



# APPLICATION FOR DISABILITY RETIREMENT

**17. DECLARATION.**

I declare under penalty of perjury that the foregoing responses contained in this Application for Disability Retirement are true and correct, and that this declaration was signed on the \_\_\_\_\_ day of \_\_\_\_\_, 2006, at \_\_\_\_\_, California.

**PROCESSING OF THIS DISABILITY APPLICATION IS CONTINGENT UPON RECEIPT OF A COMPLETED DISABILITY APPLICATION AND SUPPORTING MEDICAL DOCUMENTATION.**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Name (please print)

SAMPLE ONLY