Application Forms

Disability Retirement

Alameda County Employees' Retirement Association

Contents

ALAMEDA COUNTY EMPLOYEES' RETIREMENT ASSOCIATION
VOICE: 510.628.3000 OR 800.838.1932
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ACERA is governed by the County Employees Retirement Law of 1937 (Government Code §31450 et. seq.) as adopted and implemented by the ACERA Board of Retirement. Disability and retirement laws are complex. No statement in this Handbook is a legally binding interpretation, enlargement, or amendment of the provisions in the CERL or ACERA's policies. If conflict arises between these procedures and the CERL, the decision will be based on the CERL and other governing law.

The information presented in this Application should not be construed as legal advice or as a legal opinion on specific facts. For legal advice regarding specific facts, consult an independent attorney knowledgeable in disability retirement law matters.

Application for Disability Retirement Checklist

DISABILITY APPLICATION REQUIREMENTS***: In order for ACERA to accept and deem your application for disability retirement complete, you must submit the following required documents:

- ☐ **Application for Disability Retirement** - All medical reports and documents to support your application and establish eligibility for benefits must be submitted at the time the application form is submitted. Incomplete applications will not be accepted or processed. All questions on the application must be answered and responses must be legible. Reports and documentation submitted as attachments must be properly identified by its title, author, and date of document. The reports should also be legible.
- ☐ **Authorization to Obtain and Release Records and Information**
- ☐ **All supporting medical records and reports** - The applicant must demonstrate that he/she is permanently incapacitated from substantially performing the regularly assigned and permanent duties of his/her job. For a service-connected disability, the application and supporting medical documentation must demonstrate that the employment contributed substantially to the disability. The applicant must submit all medical records to support their disability case at the time the disability application is filed.
- ☐ **An EFJA (Essential Function Job Analysis) Form** and a copy of the member's job duties must be submitted with the application. Notify your employing department's Disability Coordinator if you cannot obtain this information. For Non-Service Connected disability application only, you may complete the "Usual and Customary Job Duty Questionnaire" in lieu of the EFJA form. The questionnaire is available upon request at ACERA.
- ☐ **A Delayed Disability Application Affidavit** must be completed by the member and the treating physician if an earlier effective date is requested and/or more than four months have elapsed from the member's last day in service (per Government Code §31722) to the filing of the disability application. The affidavit must support the member's claim of permanent incapacity. In addition, the treating physician must state that the member has been physically or mentally incapacitated from performing his or her permanent, usual and customary job duties since the date he or she discontinued service.
- ☐ **Medical Provider Statement** must be completed and obtained from a doctor with knowledge of the member's medical condition and his/hers permanent job duties.

THINGS TO DO WHEN SUBMITTING A COMPLETED DISABILITY APPLICATION:

- ☐ Schedule a counseling session to review the **Application Forms, medical reports, and Disability Application Counseling Worksheet** with a Disability Coordinator (ACERA toll free: 800-832-1932).

***Failure to submit constitutes grounds to deem your

Application for Disability Retirement incomplete and not accepted.

Application for Disability Retirement

Member Name: _____ Social Security Number: _____ - ____ - _____

I am applying for disability retirement because I believe I am permanently incapacitated from performing the duties of my permanent 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: _____

Printed Applicant Name: _____

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

Address: _____ Birth Date: _____

City & State: _____ Zip: _____ Phone: _____

Email address: _____

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 work related. 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 or work substantially contributed to injury. 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

ACERA USE ONLY
Years of Service: _____
Estimated last day in service: _____
Eligible for service retirement: ☐ Yes ☐ No
Effective date of application: _____

3. EMPLOYMENT INFORMATION: Please complete in reference to the job classification, which you are claiming you are permanently disabled from (Please do not abbreviate):

Employer Agency: _____ Immediate Supervisor: _____

Job Classification: _____ Membership Status: ☐ General Member ☐ Safety Member

Original Start Date of Employment: _____ Date assigned to job classification: _____

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 (Please explain below.) ☐ No

_____

If you are currently working in another Alameda County Employer job classification other than the one you listed above, please list the position and explain the change in position and/or department:

_____

_____

Was the change result of a reemployment plan? ☐ Yes ☐ No

If the change in position resulted in a lower monthly salary, ACERA may supplement your salary under California Gov. Code §31725.5/§31725.65 if you are ultimately deemed permanently disabled from the position you are claiming disability from. The Supplemental Disability Allowance may not exceed what the disability benefit would be.

4. RECIPROCITY: When a member who has established reciprocity with ACERA and another retirement system retires on disability, under California Gov. Code §31838.5, each system is required to pay only its proportional share of the disability allowance payment based on the portion of the overall combined service that was earned in each system. The member may not receive a total disability allowance amount equal to more than what he/she would have received had all service been earned in one retirement system. In some cases, ACERA may not be able to pay any allowance or make a refund of contributions. Please note that members who become employed with the second retirement system prior to 1/1/1984 will fall under §31837.

Please check and complete all that apply:

☐ I am currently an active member of ACERA and have a deferred retirement with (reciprocal agency): _____ Date of entry with ACERA:_____

☐ I am a deferred member of ACERA and an active member of (reciprocal agency): _____ Date of entry with reciprocal agency:_____

☐ Reciprocity does not apply

If you are an active member of ACERA, please continue to complete the rest of the Application. You must also file a disability application with the reciprocal system(s) you have established reciprocity with. Disability Application should be filed concurrently with all systems. **If you are a deferred member of ACERA, skip to Section 16, "Additional Information and Declaration" and complete. ACERA requires verification from the reciprocal agency of your disability benefit including the type (service or non-service connected), the effective date, the final average salary used, and the years of service credited in the agency and your monthly benefit amount.**

5. CURRENT STATUS: Please check any of the following that apply to you, and answer the related question.

☐ **Retirement Benefits**. Are you currently receiving any retirement benefits? Please specify (1) the company or employer; (2) the types of benefit; (3) and the effective date of the benefits.

_____

☐ **Terminal Illness and Expedited Processing of Application.** Check if you currently suffer from a terminal illness, have medical documentation regarding your status, and request expedited processing of your Disability Application.

6. EFFECTIVE DATE: If you are ultimately granted a disability retirement, your disability retirement allowance shall be effective (1) as of the date your Completed Application was filed with ACERA; or (2) the date following your last date of compensation, whichever is later. Under specific conditions as stated in California Government Code §31724 your Completed Application may be deemed filed earlier for determining an earlier effective date if you demonstrate the filing of your application was delayed by administrative oversight or an inability to ascertain the permanency of your incapacity until after your last received regular compensation

If you are requesting an earlier effective date, you must provide the information noted below.

☐ I request an earlier effective date. I have identified and attached the following information:

☐ Medical report/documentation stating I became permanently incapacitated on: _____

Determined by (Doctor): _____ Report Date: _____

AND

* State below the reason for the delay in filing your application (when filed later than 4 months after discontinuation of service*): _____

_____

_____

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

* See Cal. Gov. Code §31722

7. PURCHASE OF SERVICE: To establish eligibility for non-service connected disability, member must have five (5) years of credited service with ACERA. If you have previously withdrawn funds from a prior ACERA membership or have ineligible service, you may be able to purchase that service. If you must buy back service credit to achieve eligibility and have available service to buy, you must do so prior to completing this Application in order to receive credit for that service. [See CA. Gov. Code §31652(a).]

IMPORTANT NOTICE - READ CAREFULLY: Failure to purchase service prior to completing this Disability Retirement Application, constitutes a waiver of your rights to redeposit those contributions.

☐ I understand that I may purchase additional service credit if available from ACERA prior to completing my Disability Retirement Application in order to receive additional service credit.

☐ I do want to redeposit a prior membership or purchase ineligible service from ACERA.

☐ This does not apply, as I am retired on Service Retirement or I do not have service to purchase.

☐ I choose not to purchase available service and understand that it will affect my application to receive a non-service connected disability.

8. 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 of 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 to handle my disability retirement application. His/her contact information is listed below:

Name:_____ Firm: _____

Address: _____ Phone._____

City, State, Zip:_____

Email:_____

☐ 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 to discuss my application.

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

Are you still receiving a paycheck, including paid leave, floating holiday, sick leave or vacation time?*

☐ Yes ☐ No

*(*Please note that any of these compensation are "regular compensation" under Gov. Code §31724 and may affect/impact the date of when the disability benefit would be effective.)*

When was the last paycheck (including sick leave or vacation leave) 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:

☐ Permanent Job Duty - Usual and Customary Work, **or**

☐ Modified Work. Effective Date and end date (if known) of modified duty:_____

The modified duty is ☐ Temporary ☐ Permanent

☐ Copy of documentation/offer related to modified work/accommodation is attached to the application and dated: _____

Please complete the following if you are CURRENTLY NOT WORKING:

☐ I am currently not working for the County or other ACERA participating employers, however, I 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 §4850 Leave with Compensation

Effective Date: _____ Approximate Date Leave Ends: _____

☐ Temporary Disability (Workers' Compensation)

Effective Date: _____ Approximate Date Leave Ends: _____

☐ Permanent Disability

Date deemed unable to perform permanent job duties by medical service provider: _____

☐ Long Term Disability: (Name of Insurance Company) _____

☐ Other (Please specify): _____

Please complete the following if you are **NO LONGER EMPLOYED WITH THE COUNTY OR OTHER ACERA PARTICIPATING EMPLOYERS:**

☐ I resigned from my employment. If so, effective date and why? Effective Date: _____
(MM/DD/YYYY)

_____

☐ I took a regular service retirement. Effective Date of service retirement: _____

☐ I was terminated from my employment for cause. (Please include a copy of notice of termination and administrative appeal if applicable.)

Effective date of termination: _____

☐ I have filed an Administrative Appeal of my termination.

☐ I am in the process of being terminated.

☐ Other: Please explain _____

_____

10. PRESENT NON-ACERA EMPLOYMENT: If you are presently working for an Employer other than the County of Alameda or other ACERA Participating Employer or have worked for another Employer since you stopped working for an ACERA covered Employer (including self-employment, 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; and (3) the nature of the work.

Name of Employer	Address & Phone Number of Employer	Date(s) of Employment	Job Title/Classification
_____	_____	_____	_____
_____	_____	_____	_____

Nature of work/job description: _____

_____

_____

_____

☐ If employment is listed above, a job description must be certified from your Employer and provided with this Application. Check here if you are attaching job description.

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 or illness or disease that forms the basis of your Disability Application. Additional pages are available upon request. If additional pages are needed, please check the box below and continue on a Separate page(s). Please do not simply refer to medical reports or records. If you need to make a reference to any medical records, please specify with report name, if any, the author of the report and the date of report.

☐ _____ **(#) ADDITIONAL PAGE(S) ATTACHED.**

11.1 INJURY/ILLNESS #1:

A. Injury/Illness Type: _____

Description of Injury/Illness: _____

_____

When did you first experience the symptoms? _____

Date you first became incapacitated? _____

Physician(s) treating this injury/illness	Phone	Treatment Dates

B. 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:

Type of Treatment/Therapy	Name of Health Care Provider	Phone

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

If **yes**, please provide the following information:

1. A description of the disease: _____

_____

_____

2. When did you first experience symptoms of the disease? _____

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

_____

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

If **yes**, please provide the following information:

1. The date, time of day, and place the injury occurred:

_____

_____

_____

2. How and why the injury occurred? _____

_____

_____

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

_____

_____

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

If **yes**, please describe how: _____

_____

_____

_____

F. 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. _____

_____

_____

G. If you responded "yes" to #F, please state:

1. Date(s) of prior or similar injury, disease, symptom, complaint, disability, or condition: _____

_____

_____

2. Describe the medical treatment you received: _____

_____

3. Treatment date(s): _____

4. Describe the duration: _____

5. State the medical service provider(s) you received treatment from (name, address, and phone number):

_____

6. Describe the cause of the condition: _____

_____

_____

11.2 INJURY/ILLNESS #2:

A. Injury/Illness Type: _____

Description of Injury/Illness: _____

_____

When did you first experience the symptoms? _____

Date you first became incapacitated? _____

Physician(s) treating this injury/illness	Phone	Treatment Dates

B. If you have/or 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:

Type of Treatment/Therapy	Name of Health Care Provider	Phone

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

If **yes**, please provide the following information:

1. A description of the disease: _____

_____

_____

2. When did you first experience symptoms of the disease? _____

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

_____

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

If **yes**, please provide the following information:

1. The date, time of day, and place the injury occurred:

_____

_____

_____

2. How and why the injury occurred? _____

_____

_____

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

_____

_____

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

If **yes**, please describe how: _____

_____

_____

_____

F. 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. _____

_____

_____

G. If you responded "yes" to #F, please state:

1. Date(s) of prior or similar injury, disease, symptom, complaint, disability, or condition: _____

_____

_____

2. Describe the medical treatment you received: _____

_____

3. Treatment date(s): _____

4. Describe the duration: _____

5. State the medical service provider(s) who received treatment from (name, address, and phone number):

_____

6. Describe the cause of the condition: _____

_____

_____

12. PERMANENT INCAPACITY FROM PERFORMING JOB DUTIES: To be eligible for a disability retirement, Applicant must demonstrate that he/she is permanently incapacitated from substantially performing the permanent and 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 permanent and usual duties of your employment **at the time you became incapacitated** (include only those activities 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 incapacitated from performing one or more of the permanent 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 and that you are unable to perform your essential job duties. If you are applying for a service connected disability retirement, documentation must also include the manner in which your condition is job-related.

Please provide the name(s) of the treating doctor(s) and the date you were deemed permanently disabled and unable to perform your usual and customary du

_____

_____

Have any of your physician(s) listed a pe manent work restrictions? If yes, by whom, when and the list of restrictions:

_____

_____

Are you scheduled for su y for the injury/disease claimed or has any medical provider recommended surgery for you condition ☐ Yes ☐ No

If **yes**, when and w at type of surgery? _____

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

_____

_____

_____

What accommodation(s) have been made by your department that would allow you to return to work?

_____

_____

_____

_____

What is the period of the accommodation:_____

Are you still in the accommodating status? ☐ Yes ☐ No

If no, please explain:_____

_____

_____

Other:_____

_____

At any time since you first became incapacitated, has your condition improved enough so that you would have been capable of performing your permanent usual duties? ☐ Yes ☐ No

If **yes**, when?

_____

13. ALL MEDICAL TREATMENT WITHIN THE 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

A. 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. (Do not refer to medical records.)

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

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

14. 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 and indicate date filed:

	Date filed		Date filed
☐ Workers' Compensation	_____	☐ State Disability	_____
☐ Long Term Disability	_____	☐ Social Security	_____
☐ Unemployment	_____	☐ Arbitration/grievance	_____
☐ Other pending claim or legal action against employer	_____	☐ Administrative appeal of termination	_____

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

The nature of the claim or action: _____

_____

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.

15. SAFETY MEMBER PRESUMPTION. If you are a safety member: a firefighter, a probation officer, or a member in active law enforcement with five (5) or more years of completed service with ACERA or another California public pension plan applying because you developed permanently incapacitating heart trouble, cancer, blood-borne infectious disease, or exposure to a biochemical substance, your disability is presumed to be service connected. Please note that the claimed presumption is rebuttable/disputable by your Employer. Refer to the Disability Handbook for more information on the presumptions. Please complete the following section if your application is based on one of the presumptions.

15.1 Is this Application based on heart trouble? ☐ Yes ☐ No

15.2 Is this Application based on a blood-borne infectious disease? ☐ Yes ☐ No

15.3 Is this Application based on a disability related to any cancer? ☐ Yes ☐ No

If yes, please complete Section 15.5

15.4 Is this Application based on an exposure to a biochemical substance? ☐ Yes ☐ No

If yes, please complete Section 15.5

15.5 To be considered for the presumption of cancer (15.3) and/or exposure to biochemical (15.4), you must demonstrate you were exposed to a known carcinogen and/or biochemical substance in the course of your employment. Claiming general exposure during work-related situations is not sufficient. Please provide the following information to be eligible for the presumption. ACERA will rely on IARC (International Agency for Research on Cancer) to recognize the carcinogen type.

☐ Cancer Presumption ☐ Exposure to Biochemical Date of Exposure:_____

Circumstances of exposure: _____

_____

Type of Cancer (location of body)_____

Documentation Supporting Claim: _____

_____

*Attach additional pages if necessary concerning the exposure or documentation of your claim.

15.6 I am an eligible safety member applying for service connected disability for one of the conditions stated above, however, I am applying not based on presumption and am providing evidence supporting job-connection to my disability.

☐ Yes ☐ No Initial _____

If yes, I have provided the medical records to support my disability.

☐ Copy of medical report/documentation is attached certifying that my disability for which I am applying for disability retirement under the presumption is service connected.

Determined by (Doctor):_____ Report Date:_____

16. ADDITIONAL INFORMATION AND DECLARATION

ADDITIONAL INFORMATION

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

_____

_____

_____

_____

_____

_____

DECLARATION

I declare under penalty of perjury that the foregoing statements, claims, and responses contained in this Application for Disability Retirement are accurate, true, and correct, and that this declaration was signed on _____ at _____ California.
(month, day, year)

PROCESSING OF THIS DISABILITY APPLICATION IS CONTINGENT UPON RECEIPT OF A COMPLETED DISABILITY APPLICATION AND MEDICAL DOCUMENTATION SHOWING ELIGIBILITY FOR DISABILITY RETIREMENT.

_____ _____

Signature Date (month, day, year)

_____

Printed Name

☐ Applicant ☐ Attorney ☐ Employer ☐ Other - Filing on Behalf of Member

Relationship:_____

Authorization to Obtain and Release Records and Information

In connection with my Application for Disability Retirement, I, the undersigned, hereby authorize you to release and provide any and all of my medical, psychiatric, psychological test and lab results, billing information, and payment records to Alameda County Employees' Retirement Association (ACERA.) I also hereby authorize ACERA to procure and have in its possession all of the aforementioned medical information and records. I understand this includes, but is not limited to: hospital and other records; test results including X-rays, HIV tests, and lab reports; medical and psychological records, notes and reports; and records and/or results from any service providers. This also includes records pertaining to alcohol and/or substance abuse treatment.

I hereby authorize you to release and provide any and all information, including sealed and unsealed documents in the personnel file, payroll and other records, reports and/or items concerning all my employment, past, current, and future to ACERA. I hereby authorize ACERA to procure police and/or other reports concerning any incident in which I have been involved.

I understand that copies of records or information released will be provided to ACERA's Medical Advisor, the medical examiner in connection with an Independent Medical Examination (if requested), and to my Employer.

I acknowledge a photocopy of this document shall be as valid as the original. I understand this Authorization remains valid until the final determination of my request for disability retirement by ACERA's Board of Retirement. I may request a copy of this Authorization at any time.

I understand this release will be in effect and valid as long as my disability application is pending and for the time I receive disability retirement benefits.

I understand ACERA and my Alameda County participating Employer are materially relying on the information provided pursuant to this Authorization.

Applicant Signature: _____ Dated: _____

Applicant Printed Name: _____ (month, day, year)

Employee ID Number: _____

SSN: _____ - _____ - _____

Disability Application Counseling Worksheet

DECLARATION

I. I, _____, *(please print)* hereby acknowledge receipt of and read the ACERA Disability Retirement Handbook. Social Security Number: _____- ____ - _____

_____ _____
Member Signature Date *(month, day, year)*

II. I, _____ *(please print)* came into the Retirement Office on_____ *(date)* and received a counseling session with Retirement Specialist _____. *(name)*

I understand that my disability retirement application must be submitted with certain supporting documents and without those documents my application may be denied as incomplete, rejected or denied with prejudice and I will be determined ineligible for disability retirement benefits. _____
(Member Initial)

I had the opportunity to ask questions and receive information including the following:

ELIGIBILITY:

- ☐ **NON-SERVICE CONNECTED DISABILITY: SERVICE REQUIREMENT IS FIVE (5) YEARS WITH ACERA.** If you must purchase service to achieve eligibility and have service available to purchase, you may do so, however, the application for Non-Service Connected disability will be denied by ACERA's Board if the purchase of service is not complete. You must be permanently incapacitated for the performance of your permanent usual duties of your current job.
- ☐ **SERVICE CONNECTED DISABILITY: HAS NO SERVICE CREDIT REQUIREMENT.** You must be permanently incapacitated for the performance of your permanent job duties. The incapacitation must be a result of an injury or a disease arising out of and in the course of employment.
- ☐ **A SERVICE CONNECTED DISABILITY APPLICATION MAY DEFAULT TO A NON-SERVICE CONNECTED DISABILITY** if evidence of service connectedness is not met and your service credit total is five (5) years or more.
- ☐ ACERA disability benefits are **not the same as worker's compensation benefits.** Eligibility for Disability Retirement is based on permanent incapacity to perform your permanent usual and customary job duties, not a percentage rating or statement your medical condition is permanent and stationary.

SUPPORTING DOCUMENTS

- ☐ **ALL MEDICAL DOCUMENTATION SHOWING YOUR ELIGIBILITY FOR DISABILITY RETIREMENT MUST BE SUBMITTED AT THE TIME YOU FILE YOUR APPLICATION.** The documentation you submit must prove that you are permanently incapacitated from substantially performing your permanent usual job duties. For a Service Connected Disability, the documentation you submit must demonstrate that the employment contributed substantially to the permanent incapacitation.

SERVICE RETIREMENT

☐ **REGULAR SERVICE RETIREMENT MAY BE APPLIED FOR, IF MEMBER IS ELIGIBLE, PENDING DISABILITY APPLICATION.**

- ☐ Regular service retirement allowance based on age, years of service, and final average salary.
- ☐ Regular service retirement application packet must be completed and submitted to ACERA prior to or on effective date of service retirement.
- ☐ Eligibility to continue health, dental and vision plan coverages
- ☐ Retirement Specialist referral

☐ If you apply for regular service retirement and your disability benefit is denied, **you may not return to work for the County** or another ACERA participating employer.

EFFECTIVE DATE

☐ The effective date of the disability retirement allowance shall be either (1) as of the date your Completed Application was filed with ACERA; or (2) the date following your last day of compensation, whichever is later. Any payments received as Temporary Disability payment is also considered compensation. If you have requested for an earlier effective date, a determination will be made whether your delay in filing was due to an administrative oversight or an inability for you to ascertain your permanency of your disability. Benefit start date is governed by Gov. Code §31724.

☐ **DELAYED DISABILITY APPLICATION AFFIDAVIT**: This form must be submitted with your application if you are requesting an earlier Effective Date and/or more than four months have elapsed since your last day in service. (Per Government Code §31641 & §31722)

RETIREMENT ALLOWANCE ESTIMATES - NOT FINAL

Retirement Date used (first eligible date or current date): _____

Service Retirement allowance: $_____ per month; Date eligible:_____

Service Connected Disability: $_____ per month

Non-service Connected Disability: $_____ per month

Service Credit Total: _____ yrs FAS: $ _____

TAX WITHHOLDING/REPORTING/1099(R)

☐ Taxability of service connected disability determination. Fifty percent (50%) of final average salary is reported as non-taxable.

☐ Non-service connected disability benefit allowances are taxable and will be reported as such.

BENEFIT LIMITATIONS OF INTERNAL REVENUE CODES

The following IRS limits may apply to you:

☐ 401(a)(17) limit – annual compensation limit in final average salary.

☐ 415 limit – annual retirement benefit limit.

☐ Service Retirement pending Service Connected Disability: 1099(R) reporting of service retirement compensation is reported as "Not Determined", while disability application is pending. Depending on whether a Service Connected Disability benefit is granted or denied, the 1099(R) will report income as either taxable or non-taxable the first full year **following** the granting or denial of the benefit. This is done because a Service Connected Disability benefit may be granted retroactive to the service retirement date. **Consult your tax advisor for advice on withholding.**

FINAL RETIREMENT ALLOWANCE ELECTION/OPTION CONTRACT

☐ Upon granting of a disability benefit by the Retirement Board, it may take up to eight (8) weeks following **termination status** from your Employer to process your final retirement calculation depending on your pay status and processing of documentation with your department. An election/option contract will be processed once the final calculations are completed. You will begin receiving your monthly benefit after ACERA receives your signed election contract.

☐ ACERA provided a copy of retirement information (election contract sample) information with the disability packet.

CURRENT PAY STATUS/ACCRUALS

☐ ACERA may use the day after your last day in pay status consistent with Gov. Code §31724 to determine the start date for your benefit payment. Staff reviews all payments made to you by payroll, including accrual payments, regardless of how minimal, to determine this date. **Discuss accrual payments with your payroll department**, as this will effect your retirement benefit payments. (Please note that **temporary disability [TD]** paid by the Employer's third party administrator for Worker's Compensation pay will be considered and factored in the determination of start of disability allowance).

☐ Vacation accrual payoff upon termination of employment is included in your final average salary calculation (limited to one year's accrual for Tier I Members).

RECIPROCITY

A member who has established reciprocity (between ACERA and other system(s)) and retires on disability is subject to either of the following:

- Government Code §31838.5 requires each system to pay its proportional share of the disability payment (based on the service earned in each system) but the total allowance may not exceed what would have been received with only one system.
- Government Code §31837(3) requires that the allowance be an annuity based on the actuarial equivalent of member's accumulated contributions. This section applies to members who become employed with the second system prior to 1/1/1984.

Please indicate your reciprocal status with ACERA in one of the boxes below and state the reciprocal agency.

☐ I am currently an active member of ACERA and have a deferred retirement with (reciprocal agency):

_____

☐ I am a deferred member of ACERA and am an active member of (reciprocal agency): _____

_____

☐ I understand that due to my reciprocity memberships, my benefit from ACERA may be lower due to §31838.5 or §31837. Member initials _____ Employment entry date:_____

☐ Reciprocity does not apply

PRESUMPTION OF DISABILITY

☐ If you are a safety member with five (5) years of credited service, granted a disability retirement due to heart, cancer, biochemical, or a blood-borne disease, your disability may be presumed service connected. Your claimed presumption condition may not be attributed to any disease existing prior to your disability. Please note that the presumption may be rebuttable/disputable by your Employer.

LEGAL REPRESENTATION

☐ **RIGHTS TO REPRESENTATION BY ATTORNEY.** Any party is entitled, at their own expense, to be represented by legal counsel at any and all stages of the disability proceedings.

DOCUMENTATION NEEDED TO PROCESS BENEFITS

☐ Birth certificate/verification

☐ Marriage certificate/verification and/or state registered domestic partner certification/verification.

☐ Divorce? Domestic Partnership Dissolution? Joinder on file? DRO's needed for community property settlement.

☐ Has ACERA been joined? If yes, documentation needed.

☐ Has ACERA been served with Notice of Claim? If yes, documentation needed.

☐ Does divorce decree/judgment state ACERA benefit must be split? If yes, documentation needed.

HEALTH, DENTAL, VISION COVERAGE

☐ Effective dates of health, vision and dental coverage

☐ Reimbursement for non-ACERA coverage/Out-of-Pocket medical premiums – Members who paid out-of-pocket monthly health premiums may be reimbursed. Reimbursement is based on the disability benefit effective date and up to the maximum the member is entitled of the monthly medical allowance (MMA). Reimbursement is only authorized on paid out-of-pocket medical premiums on a monthly basis.

☐ Enrollment forms

☐ Medicare Eligible ☐ Yes ☐ No

☐ Medicare Part B Reimbursement Plan Benefit

CURRENT BENEFICIARY

☐ **Active Death Benefits**: If a member's death occurs prior to retirement, a spouse, state registered domestic partner, or minor child may be eligible for a monthly benefit amount if the member has five years of credited service, or they may elect a lump sum distribution or combination of both. If a member has less than five years, the beneficiary is entitled to a lump sum payment.

☐ **Retired Death Benefit**: A member may choose to leave a monthly continuance to an eligible beneficiary. The amount will vary depending on the retirement option they choose. There is also a $750 lump sum death benefit payable to any beneficiary.

☐ Complete Active/Deferred Member & Disability Beneficiary Designation forms.

Note: A current spouse or minor child has legal rights to your retirement death benefits.

CONTINUANCE OF APPLICATION UPON DEATH

☐ If your death occurs during the application process, your application may be continued by anyone on your behalf. However only the named beneficiary will be entitled to the death benefits.

Please feel free to contact a Retirement Specialist at a later date if you have questions concerning your benefits or any of the above items. The Retirement Specialist has reviewed all of the items on this checklist with me.

Signature of Member: _____ Date: _____
(month, day, year)

Signature of Retirement Specialist: _____ Date: _____
(month, day, year)

Delayed Disability Application Affidavit

This form must be completed by the Applicant and his/her's physician if the application is not filed within four months of discontinuation of service and/or the Applicant is requesting an earlier effective date.*

Member Name: _____
(Last) *(First)* *(Middle Initial)*

Social Security Number: _____- _____ - _____

GENERAL INFORMATION

Section 31722 of the California Government Code states:

31722. Time for Application.
The application shall be made while the member is in service, within four months after his or her discontinuance of service*, within four months after the expiration of any period during which a presumption is extended beyond his or her discontinuance of service, or while, from the date of discontinuance of service to the time of the application, he or she is continuously physically or mentally incapacitated to perform his or her duties.

The Member/Applicant must complete the first page of this form regarding their last day at work and have the physician treating the medical condition, injury or disease complete the second page of this form.

If completed correctly, this document will be considered as evidence to determine if the Member has been continuously incapacitated from the time they were in service and/or eligible for earlier effective date.

Any application for disability retirement submitted to ACERA later than four months from discontinuation of service must include this completed form. Any such application for disability retirement will not be accepted unless this affidavit is completed and submitted to ACERA with the application.

MEMBER EMPLOYMENT INFORMATION

The date service* was discontinued from the position for which the disability claim is being filed (last day at work): _____(mm/dd/yyyy)

* See Cal. Gov. Code §31641

Member Name: _____

MEMBER'S PHYSICIAN TO COMPLETE THE FOLLOWING:

PHYSICIAN STATEMENT

I, _____, am a state licensed _____
(Physician's Printed Name) *(Type of Medical License)*

The above-named person has been under my care for the following time:

_____ to _____

My care of this person ☐ has ☐ has not been continuous since the date the member became permanently incapacitated.

I have treated this person for the following medical condition, illness, or disease:

_____

_____

☐ I have reviewed this person's permanent usual and customary job duties and I have reviewed the attached:

EFJA Form dated _____.

It is my medical opinion that this person:

☐ is **not** currently permanently incapacitated from performing his or her permanent usual and customary duties of their job.

☐ is currently permanently incapacitated from performing his or her permanent usual and customary duties of their job since _____ (date).

I have provided continuous medical care to this person since this person became permanently incapacitated. Please state all the facts you rely on and the source of the facts to form your opinion that this person is permanently incapacitated (i.e. objective medical test results):

_____

_____

If you have not provided continuous care to this person since the date this person became permanently incapacitated, state the medical reports you are relying on for your decision (include reporting physician's name and report date).

_____

_____

I declare under penalty of perjury that the information supplied in this statement and the questions answered are true and correct, and this declaration was signed this _____ date of _____ 20_____ at _____, California.

Physician signature: _____ Print physician's name: _____

Physician's address: _____

Physician's phone: _____

Member Name: _____

Instructions to Member: Please provide this "Medical Provider Statement" form to each treating doctor for each injury/illness you base your disability application on. Example: One "Medical Provider Statement" to each of your doctor(s) treating you for injury #1; one "Medical Provider Statement" to each of your doctor(s) treating you for injury #2. (You may copy form for your use.) You must also attach an Essential Functions Job Analysis (EFJA) in order for your doctor to answer the following questions.

Medical Provider Statement (REQUIRED)

Physician: The above-named ACERA Member ("Applicant") is in the process of applying for Disability Retirement with the Alameda County Employees' Retirement Association ("ACERA"). As part of this process, ACERA requires that the Member obtain a statement from a physician familiar with the Member's medical condition. This Statement shall state whether, in the physician's opinion, the Member is permanently incapacitated from performing the permanent usual and customary duties of his/her position. A permanent incapacitation may be the result of an injury, illness or disease. The cause may or may not be work-related.

You must review a description of the Member's permanent job duties, a Description of Employee's Essential Job Functions, prior to providing your Medical Provider Statement.

Please answer the following questions for each injury/illness for which you are treating the Applicant.

1) Please state the first date you treated/examined the Applicant?_____

2) Please state the last date you treated/examinated the Applicant? _____

3) What is your current diagnosis of the Applicant?_____

_____

_____

a) When did you first make this diagnosis? _____

b) Was this diagnosis first made by another physician/treater? ☐ Yes ☐ No

4) What is your current prognosis of the Applicant?

_____

_____

a) When did you first make this prognosis? _____

b) Was this prognosis first made by another physician/treater? ☐ Yes ☐ No

5) In your opinion, is Applicant's injury/illness/medical condition:

☐ Worsening? If yes, why do you so conclude? _____

_____

☐ Improving? If yes, why do you so conclude? _____

_____

☐ Remaining the same? Please describe the current condition that is remaining the same and why do you so conclude? _____

_____

_____

6) Is there a medical treatment summary or therapy which the Applicant could benefit from?

☐ If yes, please describe: _____

☐ If no, please explain why: _____

7) In your opinion, is Applicant's injury/illness/medical condition permanent? ☐ Yes ☐ No

a) If yes, on what date did the condition become permanent? _____

b) How was permanency determined? _____

_____

c) Were you the first physician/treater to determine permanency? ☐ Yes ☐ No

i) If yes, please list the date period you have treated the Applicant _____

ii) If no, who was? _____

8) How does Applicant's medical condition/injury/illness permanently incapacitate Applicant from performing their permanent and usual job function?

_____

_____

9) State the objective medical test results and dates of the results you rely upon that is the basis of your opinion of the Applicant's permanent incapacitation for this injury/illness:

_____

_____

10) Have you recommended an accommodation which will allow Applicant to continue to perform the above permanent and usual job duty?

☐ If yes, state the accommodation: _____

If yes, state the date you recommended the accommodation: _____

☐ If no, describe why not: _____

11) Did the Applicant's County employment contribute to the medical condition/injury/illness?

☐ Yes ☐ No

If you answered "yes", state all the facts you base your opinion: (Include name of physician and date of physician's report.)

_____

_____

12) Did anything else (i.e., other employment, prior employment, non-work related events) contribute to the medical condition/injury/illness? ☐ Yes ☐ No If yes, what were they:

_____

13) In your opinion, what is the cause of Applicant's medical condition/injury/illness?

_____

I declare under penalty of perjury that the information supplied in this statement and the questions answered are true and correct, and this declaration was signed this _____ date of _____, 20____ at, _____, California.

Physician's signature:_____ Printed physician's name:_____

Physician's address:_____

Physician's phone: (____) _____

Please direct the original copy of your report to the following address:

Alameda County Employees' Retirement Association
475 - 14th Street, Suite 1000
Oakland, CA 94612
Attn: Disability Unit