COAERS
CITY OF AUSTIN
EMPLOYEES' RETIREMENT SYSTEM

DISABILITY RETIREMENT APPLICATION AND INSTRUCTIONS

Disability Retirement Application Instructions and Important Information

To be eligible for disability retirement benefits with COAERS, you must meet the following conditions:

1. Be an active-contributing or inactive-contributing member; OR
2. Be on approved medical leave of absence; OR
3. If terminated from City employment, make application for disability retirement benefits within 90 days of termination; AND
4. Have a minimum of five years Creditable Service in COAERS unless the disability is the direct result of an on-the-job injury/illness with the employer (City or COAERS) subsequent to your effective date of membership; AND
5. Be physically or mentally incapacitated for the performance of ALL employment duties; AND
6. Have an incapacitation for all job duties which is expected to be permanent.

Members who are terminated from City employment for inability to perform all employment duties must make application for disability retirement benefits within 90 days of termination. It is the member's responsibility to confirm his/her date of termination and to apply for disability retirement benefits within the 90-day period. If you are not sure of your date of termination, it is <u>your</u> responsibility to contact your City department and confirm your date of termination.

Employees are encouraged to check with their disability insurance provider (e.g. Short and Long Term Disability coverage) to determine how disability retirement from COAERS will affect the amount they will continue to receive from this benefit.

Members are encouraged to submit either a completed Member Statement or a completed Physician Statement as soon as possible in order to establish a date on which their application is received. However, it is in your best interest to submit all of the required documentation as part of the application packet prior to your hearing with of the COAERS Board of Trustees.

Documentation Requirements

It is ***<u>required</u>*** that Members submit the following documents to COAERS regarding their disability retirement application:

- COAERS' *"Member's Statement - COAERS Disability Retirement Application" (see attached.).* The original Member's Statement must be notarized. A person having a Power-of-Attorney or Guardianship for the Member may complete the Member's Statement, provided that original documentation of the Power-of-Attorney or Guardianship is attached to the Member's Statement.
- COAERS' *"Physician's Statement - COAERS Disability Retirement Application" (see Attachment A.2.)* from ***ALL*** physicians treating you for the disabling condition since onset of the illness or

injury. *NOTE:* You must sign the *"Request and Legal Release from Member*" section on the front page of the *"Physician's Statement on Disability*" authorizing release of medical records *prior* to submitting the forms to each physician. Statements must be from a M.D. (family practitioner or medical specialist) or D.O. (osteopathic medicine); statements from chiropractors will be insufficient. Original completed statements must be submitted from each physician treating you for the disabling condition since the onset of the illness or injury. Note that all forms must be legible and answered fully.

- A complete copy of **all** of your medical records is required, including all notes, narrative reports, and test results from **all** physicians treating you since the onset of the illness or injury.
- Copies of medical records must also be submitted from **all** physicians treating you for **any other** medical problem (e.g. diabetes, high blood pressure, heart problems, etc.) during the past two years, even if the physician is not currently treating you.

It is your responsibility to submit full and complete information at your own expense. Copies of medical records provided to COAERS become the property of COAERS. In addition, please be advised that you maybe requested to provide additional information and/or obtain examination(s) by a physician(s).

The disability determination will be based on your mental or physical incapacitation as of the date of yourapplication for disability retirement. All information provided in the disability retirement application packet as of the date the Board reviews your disability retirement application will be considered in the Board's decision. New information will be considered if requested by the Board. Any medical condition(s)not defined or existing on the date of your date of application is not applicable and will not be consideredin the disability application process.

As a general rule, the Board will take action on an application for disability retirement within six months of the date the disability retirement application was received. Applications will be denied if you have failedto establish a likely permanent inability to perform all employment duties as of your date of application for disability retirement.

The completed application packet should be forwarded to COAERS by mailing or delivering it to:

City of Austin Employees' Retirement System
4700 Mueller Blvd, Suite 100
Austin, TX 78723

Disability Retirement Application Process

All documents filed with COAERS will be held in the strictest confidence permitted under the law. Once received, the application forms and supporting documentation will be evaluated by a third party MedicalConsultant. The Medical Consultant will submit a written opinion to the COAERS' Board of Trustees advising if, in his/her professional opinion, whether your disability condition meets the definition of disability as defined in COAERS' governing statute.

Generally, the Board will consider and take action on a disability retirement application at the next regularly scheduled meeting after receipt of the Medical Consultant's opinion. You will be notified in writing of the scheduled meeting.

You may be requested to provide additional information and/or obtain examination(s) by a physician(s) as determined by the Board of Trustees/Disability Committee. While the COAERS staff provides general assistance and information to Members regarding disability retirement applications and procedures, the burden of proof remains on you to establish a likely permanent inability to perform **all** employment duties. Members who, due to illness, injury, or disability, desire COAERS to make an accommodation in the process, schedule, time requirements, or otherwise, for considering an application, must submit a written request for the accommodation to the Executive Director/designee.

The Board of Trustees, in its sole discretion, will make a decision, based on the record and evidence submitted in the application and medical records, to approve or disapprove disability retirement benefits. You will be notified in writing of the Board's decision. If the Board approves disability retirement benefits, you will be notified of the retirement process, including your approved retirement date. If the Board denies disability retirement benefits, you will be notified of our appeals process. The decision of the Board of Trustees on an appeal is final.

Please be advised that the Board may, as appropriate, require that a Guardian be appointed for a Member in cases where it has been represented or evidence shows that the member is mentally incompetent or the member has applied for disability on the basis of mental incapacity. Such Guardianship may be required prior to processing the disability retirement and disbursement of the retirement annuity payments.

Disability Retirement - Continuation Process

Unless specifically exempt by Board action, if you are approved for disability retirement, you will periodically be required to provide proof of continued disability and will annually be required to provide employment and income documentation to the Board. In addition, disability Retirees are required to submit to examination(s) by physician(s) if and when required. The COAERS Board of Trustees has the right to request financial reviews and order examinations of any member on disability retirement until the Member reaches the normal retirement age.

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Member's Statement
COAERS Disability Retirement Application

This statement must be made by the COAERS member applying for disability benefits. An Attorney-in-Factor Court appointed Guardian may complete and present this statement, provided that original documentation of the Power-of-Attorney or Guardianship is attached. All questions must be answered fully. Additional pages may be attached as needed for any response. Corrections must be initialed. COAERS reserves the right to reject the form if not legible.

Name:	
SSN:	
Address:	
Email:	
Phone:	
Date of Birth:	
Date of Hire:	
Current or Last Department:	

Complete the following information.

1. Job Title of Your Current Position: _____
2. Job description (specific activities): _____
   _____
   _____
3. Last day worked due to disability: _____
4. List all previous adult work experience: _____
   _____
   _____

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5. Indicate your education and training:

	Years/Hours completed	Graduated	Location
Elementary school			
High school			
College			
Specialty school			
Technical school			

6. Describe your medical problem(s), by answering the following questions,
   a. What is your ***medical diagnosis*** that limits your work?_____
   b. How did the injury or illness occur? _____
   c. Date injury or illness first occurred? _____
   d. What types of activity bother you most? _____
   _____
   e. What specific activities does this injury or illness prevent you from doing? _____
   _____
   f. Did you have any previous difficulty with the same problem?

   ☐ Yes ☐ No

   Explain and provide dates you experienced the same problem:
   _____
   _____
   _____

7. Have you previously applied for disability retirement with the City of Austin Employees' Retirement System?

   ☐ Yes ☐ No

   If yes, when? _____

8. If your disability is job related, describe how you were injured and when:
   _____
   _____
   _____

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9. Do you feel your condition is: getting worse, is stable, or is improving?

Please explain: _____

10. What normal activities are prevented by the claimed disability?

11. Have you engaged in or applied for any employment other than with the City of Austin during the pastyear?

☐ Yes ☐ No

Please explain. _____

12. Have you undergone or are you currently participating in vocational/physical therapy rehabilitation?

☐ Yes ☐ No

If yes, explain. _____

13. Have you undergone or are you currently participating in any job or vocational training?

☐ Yes ☐ No

If yes, explain. _____

14. Have you ever been on active duty in the United States Armed Forces?

☐ Yes ☐ No

If so, which branch?_____

15. Have you ever received a service connected disability from the Armed Forces?

☐ Yes ☐ No

If so, what condition? _____

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16. Have you ever been treated by a Veteran's Administration (VA) hospital facility?

☐ Yes ☐ No

If so, which one and for what condition(s)? _____

_____

17. List ALL physicians consulted for ***this*** medical problem and include the dates of treatment *(NOTE: Completed physician statements and copies of **all** medical records must be submitted from each of these physicians.)*:

Name	Mailing Address	Date

18. List ALL physicians who have treated you for ***any other*** medical problems (e.g. diabetes, high blood pressure, heart problems, etc.) during the past two years, other than those listed above, including medical diagnosis and dates of treatment *(NOTE: Copies of **all** medical records must be submitted fromeach of these physicians)*:

Name	Mailing Address	Diagnosis	Date

19. List all hospitalizations and operations:

Hospital	Treatment or Operation	Date

20. List names of all medicines and daily dosage you now take and the name of the prescribing doctor:

Medicine	Dose Per Day	Condition being treated	Prescribing Doctor

21. Have you followed all of your doctor's recommendations?

☐ Yes ☐ No

If no, explain: _____

_____

22. City of Austin Employees' Retirement System (COAERS) Members may be entitled to disability retirement benefits provided the member is mentally or physically incapacitated for performance of all employment duties and the incapacity is likely to be permanent. The member must be either an active-contributory Member, an inactive contributory Member, or be on approved medical leave of absence.

a. Are you still employed with the City of Austin or have you been terminated 90 days or less for your inability to perform your employment duties? ☐ Yes ☐ No

Members who are terminated from City employment for inability to perform all employment duties must make application for disability retirement benefits within 90 days of termination. It is the member's responsibility to confirm his/her date of termination and to apply for disability retirement benefits within the 90-day period. If you are not sure of your date of termination, it is <u>your</u> responsibility to contact your City department and confirm your date of termination.

b. How long is your disability expected to continue? _____

_____

c. What changes are expected relative to your disability? _____

_____

23. The COAERS Board may, as appropriate, require that a Guardian be appointed for a member in cases where it has been represented or evidence shows that the member is mentally incompetent or the member has applied for disability on the basis of mental incapacity. Such Guardianship is required prior to processing the disability retirement and disbursement of the retirement annuity payments. Do you feel that you are competent and capable of handling your personal affairs?

☐ Yes ☐ No

24. Provide any other facts or medical information you feel would support your request for disability retirement (attach additional pages if needed):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

****

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Read and then sign this page.

I, the undersigned, do hereby make and submit this application required for disability retirement benefits and upon my oath do state that I am above the age of 18, that I am a member of the City of Austin Employees' Retirement System, and that I expressly waive all provisions of law prohibiting anyphysician and any other person who has attended me from disclosing any knowledge or information which he/she thereby acquired.

I hereby consent to and authorize my physician to release a complete copy of my medical record, including all notes, narrative reports, and test results to the City of Austin Employees' Retirement System. I authorize the release of employment records including, but not limited to, job descriptions and my personnel history; I also authorize the release of my employer's records including workers' compensation records, reports of accidents, and physician letters and reports.

I hereby consent to and authorize the City of Austin Employees' Retirement System to release medical information, which it has or may have, to any physician for the purpose of reviewing and making a recommendation on this application. Further, I hereby expressly consent to the release of all medical information concerning my condition to any medical consultant/vocational rehabilitation specialist selected by the Board of Trustees of the City of Austin Employees' Retirement System.

I further certify that the above statements were made by me, that they are complete and true to the best of my information, knowledge, and belief, and that they are made for the purpose of securing disability retirement benefits, in compliance with the disability provisions of Art. 6243n., Tex. Rev. Civ. Stat., and the System's rules, regulations, and policies. I understand that any misstatement, misrepresentation, or omission of fact could result in denial, suspension, or termination of disability retirement benefits. I also understand that falsification of any information or record or the acquiescence in falsification of any information or records submitted to the System is deemed a Class B Misdemeanor and may result in criminal charges being pursued. I understand that it is my responsibility to submit evidence of total and permanent disability due to my being mentally or physically incapacitated for the performance of all employment duties. I also agree that a copy of this authorization will be considered as effective and valid as the original.

Member's Printed Name:	
Member's Signature:	**Date:**

NOTARY

State of_____ County of_____ Before me, the above named individual personally appeared and he/she is known to me to be the person whose name is subscribed to the foregoing instrument and acknowledged to me and executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this_____ day of_____, 20_____.

Notary Public's Signature: _____

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Physician's Statement
COAERS Disability Retirement Application

The City of Austin Employees' Retirement System (COAERS) is respectfully asking for your professional opinion to help us decide whether the patient named below is eligible for disability retirement benefits. We appreciate your time and attention to this matter as it is of importance to the patient and to the Board and staff of COAERS.

Patient Information

Name:	
SSN:	
Address:	
Email:	
Phone:	
Date of Birth:	
Date of Hire:	
Current or Last Department:	

Patient Release

I am applying for permanent disability retirement benefits from the City of Austin Employees' Retirement System (COAERS). Please furnish me a ***complete*** copy of my medical records, including all notes, narrative reports, and test results, to accompany this Physician's Statement.

_____ _____

Patient Signature **Date**

Physician Information

Name of Attending Physician	**Address**
Physician's Area of Expertise or Specialty	**Board Certification (List all applicable certifications)**

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1. Diagnosis of Disability (do not use Diagnosis codes):

_____

_____

2. a. Date of onset: _____
   b. Date of first visit to your office for this disability: _____
   c. Date of last examination: _____
   d. Are you still attending the member?

   ☐ Yes ☐ No

3. Briefly describe etiology, severity, course of disorder, treatment, response to treatment, and othersignificant details pertinent to your diagnosis. Please use the back of the form or attach additional sheets if necessary.

_____

_____

_____

_____

_____

4. Give findings, whenever available, in regard to:
   a. Height:_____ft._____in.
   b. Weight:_____lbs.
   c. Blood pressure: _____
   d. Pulse: _____
   e. Respiration: _____
   f. Temperature:_____

5. Give ***abnormal*** findings to support diagnosis: (Use reverse side if necessary)

   a. Head and Neck and ENT:_____
   b. Chest: _____
   c. Heart: _____
   d. Abdomen: _____
   e. Extremities: _____
   f. Neurological: _____
   g. Psychiatric: _____
   h. Laboratory (copies required): _____
   i. Special tests (copies required): _____

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6. List additional diagnoses or medical problems of this patient:

Diagnosis	***Dates***

7. What medications and doses are you prescribing for this patient?

_____

_____

8. In your opinion, is this patient competent and capable of handling his/her own personal and financial affairs?

☐ Yes ☐ No

9. Has this patient been compliant with your care and advice?

☐ Yes ☐ No

10. Describe physical and/or mental/cognitive limitations of patient: _____

_____

_____

11. From present indications, what seems to be the most probable course of this patient's illness or injury?

_____

_____

_____

12. According to the provisions of the City of Austin Employees' Retirement System, a Member of the Retirement System is entitled to disability retirement benefits provided the Member is mentally or physically incapacitated to engage in ***all employment duties*** (not just their City of Austin job duties) and that such incapacity is likely to be ***permanent.*** In your opinion, does the disability ***completely*** prevent patient from engaging in ***any and all*** employment duties?

☐ Yes ☐ No

If yes, please skip questions #13 and #14

13. In your opinion, what type of job duties could this patient perform?

_____

_____

14. In your opinion, is your patient able to be employed in some sedentary work activity?

☐ Yes ☐ No

15. Please provide any additional pertinent remarks/information/insights:

_____

_____

_____

I, the undersigned, do certify that the above statements and answers were made by me, and that said statements and answers are each and all complete and true to the best of my knowledge, information, and belief. I am licensed to practice medicine in the State of Texas.	
Name of Attending Physician	**Signature of Attending Physician**
Address	**Date Signed**
City State Zip	**Phone Number**
Area of Expertise/Specialty	**Board Certification (List all applicable)**