DISABILITY BENEFIT APPLICATION

Ohio Public Employees Retirement System
277 East Town Street, Columbus, Ohio 43215-4642
1-800-222-PERS (7377)
www.opers.org

Please complete this form in its entirety. Failure to complete this form in its entirety could result in a delay in processing. OPERS' third party administrator, may be contacting you regarding your application for disability benefits.

See next page

STEP 1: Member's Personal Information

Social Security Number

___ — ___ — ____

-OR-

OPERS ID

First Name

MI

Last Name

Date of Birth

__ __ / __ __ / __ __ __ __

Gender

◯ **Male** ◯ **Female** ◯ **Prefer Not To Say**

Address

City

State

ZIP Code

Home Phone Number

___ — ___ — ____

Work Phone Number

___ — ___ — ____

Cell Phone Number

___ — ___ — ____

Preferred Telephone Number for Contact:

◯ Home ◯ Work ◯ Cell

Preferred Time to Call:

◯ Morning ◯ Afternoon ◯ Evening

E-mail Address

STEP 2: Member's Physician Information

If you have multiple physicians, each physician must complete a *Report of Physician* form (DR-APS) on your behalf. The physician must be a licensed and practicing physician (MD or DO). It is important to provide contact information. Please notify us if a physician you have indicated will not be submitting a DR-APS on your behalf.

Physician Name MD DO

Physician Office Mailing Address

City State ZIP Code

Physician Office Phone Number Fax Number

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Will this physician be submitting a *Report of Physician* form (DR-APS)? ◯ Yes ◯ No

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Physician Name (2) MD DO

Physician Office Mailing Address

City State ZIP Code

Physician Office Phone Number Fax Number

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Will this physician be submitting a *Report of Physician* form (DR-APS)? ◯ Yes ◯ No

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Physician Name (3) MD DO

Physician Office Mailing Address

City State ZIP Code

Physician Office Phone Number Fax Number

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Will this physician be submitting a *Report of Physician* form (DR-APS)? ◯ Yes ◯ No

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STEP 3: Social Security Disability Insurance

If you are approved for an OPERS Disability Benefit and you are eligible to apply for Social Security Disability Insurance (SSDI), you are required to apply, and provide a copy of the SSDI benefit application, not later than 90 days from the OPERS Board of Trustees approval date of your disability benefit application. This requirement does not apply to members in the OPERS law enforcement division. If you are not sure if you are eligible for an SSDI benefit you can find out by going to ssa.gov or by contacting Social Security at 1-800-772-1213.

Are you currently receiving a Social Security Disability Insurance benefit?

◯ Yes ◯ No

Are you eligible to apply for a Social Security Disability Insurance benefit?

◯ Yes ◯ No

Do you have at least five years of OPERS service credit for the same periods during which you had earnings from other employment that was taxable under Social Security (FICA tax) for any time period prior to your application for disability benefits?

◯ Yes ◯ No

STEP 4: Other Retirement System Service Information

If you are currently a member or have been a member of any of the following retirement systems, please complete the following. If you have never been a member of one of the retirement systems listed below, please check this box: ☐

	Currently a member?		Have been a member?
Ohio Police and Fire Pension Fund (OP&F)	☐	or	☐
State Highway Patrol Retirement System (HPRS)	☐	or	☐
Cincinnati Retirement System (CRS)	☐	or	☐
State Teachers Retirement System (STRS)	☐	or	☐
School Employees Retirement System (SERS)	☐	or	☐

If you have refunded from either STRS or SERS, are you interested in purchasing this time to be included in the calculation of your benefit?

◯ Yes ◯ No

If you have membership with SERS and/or STRS, this credit may be used in the calculation of your OPERS benefit or you may elect to retire on an independent basis using only OPERS service and salary.

◯ NO, DO NOT combine my SERS and/or STRS account with my OPERS account

◯ YES, DO combine my SERS and/or STRS account with my OPERS account

See next page

STEP 5: Other Service Information

Are you in the process of, or planning to, purchase service credit?

◯ Yes ◯ No

If yes, what type? _____

STEP 6: Rehabilitative Services

OPERS offers Rehabilitative Services to our disability benefit recipients to assist them with maximizing their functionality and employability. Please choose one of the following options.

◯ If my application is approved, I choose to actively participate in Rehabilitative Services. I understand that by actively participating in Rehabilitative Services I will remain on a leave of absence from my last public employer and continue to be evaluated under the **own occupation** standard for up to five years following the effective date of my benefit. If at any time after my third benefit anniversary I stop participating in rehabilitative services, my disabling condition will be reviewed immediately under the **any occupation** standard. Furthermore, I understand that upon the expiration of my leave of absence period I will be evaluated under the **any occupation** standard.

-OR-

◯ If my application is approved, I choose not to participate in Rehabilitative Services. I understand that by not actively participating in Rehabilitative Services my leave of absence from my last public employer will be limited to three years following the effective date of my benefit. Furthermore, I understand that upon the expiration of my leave of absence period I will be evaluated under the **any occupation** standard.

See next page

STEP 7: Banking Information

Bank Name

Bank Address

City

ZIP or Postal Code

State or Province

Country

Bank Routing Number

Account Number

(Choose only one)

◯ Checking **-OR-** ◯ Savings

Example Check > Valid routing numbers begin with 0,1, 2 or 3

See next page

STEP 8: Member's Authorization and Acknowledgment

HIPAA DISCLOSURE:

I authorize any licensed physician, medical provider, medical facility, or provider of health care or similar entity to release any and all of the following information to OPERS or its third party administrators. I understand if there are any expenses for releasing this information it is my responsibility to pay those expenses.

Medical information with respect to any physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, and mental health.

I understand the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, return to employment opportunities, and assessment of ongoing treatment. Any information obtained will not be released to any person or organization except OPERS and its third party administrators.

I agree that a photographic copy of this Authorization shall be as valid as the original.

I understand that I may request a copy of this Authorization. This Authorization shall become effective on the date appearing next to my signature below.

I understand I have the right to revoke this Authorization at any time by notifying OPERS.

I understand that revoking this Authorization may impair necessary processing of my application.

Being duly sworn, I, the undersigned, state that the information I provided in this Application is complete and true to the best of my knowledge and belief.

I understand that, by applying for disability benefits, I am consenting to undergo medical examinations by an OPERS-appointed, independent medical examiner(s) and authorize my physician(s) to provide OPERS with my medical information.

I acknowledge that, if my application is approved, I must terminate public employment not later than the month following the month in which the OPERS Board approves my application.

I acknowledge that if I do not terminate public employment within this time frame, my application will be void, my disability benefit will not be paid and will be forfeited, and, if I am eligible, I may file a new disability application.

I acknowledge that I have received and reviewed the OPERS Disability Benefits leaflet and the Member Handbook concerning disability benefits. If I am approved by the OPERS Board for disability benefits, I acknowledge that this approval may be contingent upon my receiving continued medical treatment for my disabling condition.

Additionally, I acknowledge that my disability benefits will be terminated should I return to public employment or service as an elective official.

Member Signature _____ Today's Date ____/____/____

Do not print or type name


OPERS