maine PERS Public Employees Retirement System
P.O. Box 349
Augusta, ME 04332-0349
Telephone: (207) 512-3100
Toll-free: 1-800-451-9800
Fax: (207) 512-3285
TTY: (207) 512-3102

APPLICATION FOR DISABILITY RETIREMENT BENEFITS (Instructions)

Completing the Application

The Maine Public Employees Retirement System (MainePERS) Application for Disability Retirement Benefits is available in the Disability Section of our web site at www.mainepers.org. The application, and accompanying forms, may be filled in online, but you need to print and mail your completed forms to MainePERS. Whether you decide to print the application and complete it yourself or you obtain assistance from the MainePERS Disability Unit, please be sure to read *An Overview of Disability Retirement Benefits* beforehand. A copy of this publication can be mailed to you upon request or you can download it from the Disability Section of mainepers.org.

MainePERS will use the application to document your claim for a disability retirement benefit. Your disclosure of the information requested is voluntary, but failure to provide all of the requested information may affect the determination of your claim. MainePERS will keep your medical records confidential with the exception that they may (1) be released to your employer for purposes relating to any claim for Workers' Compensation or any other benefit and/or (2) be subject to disclosure in proceedings resulting from an appeal. If your employer makes a request to obtain your medical records, MainePERS will notify you in writing of such a request.

Work-Related Injury or Accident

If any of the condition(s) you are applying for are the result of an injury or accident received in the line of duty, provide proof of your application for Workers' Compensation benefits. Workers' Compensation is considered earnable compensation and you will continue to receive creditable service towards retirement. You must pay the employee share of any MainePERS contributions due on Workers' Compensation payments received while still employed. If you are receiving Workers' Compensation payments, you should contact MainePERS to make arrangements to pay these contributions.

Social Security

If an employer that is also covered under the United States Social Security Act employs you, provide documentation from Social Security confirming they have received your completed application and that it is in process.

MainePERS Membership Status

MainePERS membership is one of the requirements for disability benefit applicants. Therefore, disability applicants may not apply for and receive a refund of contributions or apply for and receive service retirement without jeopardizing their eligibility to apply for disability benefits.

MainePERS Group LIfe Insurance

If you participate in the MainePERS Group Life Insurance Program and you begin an unpaid leave, please contact the Survivor Services Unit for information regarding the maintenance of continued coverage. Payments must be made to continue coverage.

Questions and Assistance

Contact the Disability Unit with any questions or if you would like assistance in completing the application. Once you have submitted the application and release forms, you will be assigned a Specialist who will be your contact person throughout the disability application process.

P.O. Box 349
Augusta, ME 04332-0349
Telephone: (207) 512-3100
Toll-free: 1-800-451-9800
Fax: (207) 512-3285
TTY: (207) 512-3102

APPLICATION FOR DISABILITY RETIREMENT BENEFITS

Member Name: ______ (Prefix) ______ (First) ______ (MI) ______ (Last) ______ (Suffix)

Last Four Digits of Your Social Security Number: ______

E-mail: ______

Mailing Address: ______ (Street/PO Box) ______ (City) ______ (State) ______ (ZIP)

Daytime Phone #: ______ Alternate Phone #: ______

Employer: ______ Job Title: ______

Estimated Hire Date: ___ (mm) ___ (dd) ___ (yyyy) Estimated date you began this job: ___ (mm) ___ (dd) ___ (yyyy)

Are you still working?: ❑ Yes ❑ No If No, enter date last worked: ___ (mm) ___ (dd) ___ (yyyy)

Date leave without pay began: ___ (mm) ___ (dd) ___ (yyyy) Date of Termination: ___ (mm) ___ (dd) ___ (yyyy)

List the condition(s) for which you are applying for disability benefits, that make it impossible for you to do your job. Information about symptoms can be helpful, but please list the specific condition the symptoms are related to.

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______

Have you applied for Workers' Compensation for any of the above conditions?
❑ Yes (If Yes, attach a copy of the first report of injury) ❑ No

Have you received Workers' Compensation benefits for any of the above conditions?
❑ Yes (If Yes, attach a copy of the decision) ❑ No

Have you applied for Social Security disability benefits?
❑ Yes (If Yes, provide documentation from Social Security confirming they have received your completed application and that it is in process) ❑ No

Form #: DC-0003
Rev. 10/15

Describe how the conditions you listed on the previous page make it impossible to perform your job duties:

Medical Providers

List the names and addresses of all physicians/hospitals that you have seen or visited for the conditions you have listed on page 1. (Please use an additional sheet of paper for additional providers.)

	Name	Address	Telephone number
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Release of Information

I authorize any current or former company, state, teacher or participating local district employer, healthcare provider, and/or governmental agency to provide to MainePERS any information or records including, without limitation, any and all medical records, personnel or employment records, including disciplinary and termination records, photographic and digital representations and/or insurance benefit records. I hereby waive my rights to confidentiality in all records relating to my employment records, including, but not limited to, disciplinary and termination records.

I understand that additional providers may be referenced in provider reports previously identified and those records may also be disclosed under this release. I authorize the release of information pertaining to periodic requests to determine any return to employment during the pendency of this application and appeal. Finally, I authorize the release of my home contact information defined as "home address, home telephone and cell phone number, home fax number and home e-mail address," for the duration of the processing of my disability application, including the period of time needed for any payroll processing and/or any appeal resulting from my application for disability benefits. I may not designate selective release of my home contact information.

I agree to provide change in contact information to MainePERS within ten (10) days of the change. I further agree to notify MainePERS if I return to work during the pendency or the application or appeal.

A photocopy of this statement will be treated as an original. I certify that the above statements are true. I understand that the medical records supplied by the healthcare providers may constitute the sole basis for determining my eligibility to receive disability benefits. MainePERS may, at its discretion and its expense, require further medical examination(s) prior to making the final decision.

Signature of Applicant: ______________________________ Date: ____________________

Note: If this form is completed by someone other than the applicant, please sign and explain below:

Signature: ______________________________________ Date: ____________________

Your Name (print or type): ____

Relationship: ____

Explanation of why you are completing this form for the applicant:

____

____

____

If you believe you have the authority to sign this form on behalf of the applicant, state the basis of your authority. If the basis of your authority is set forth in a document(s), such as a power of attorney or appointment of guardianship, attach copies of all relevant documentation.

P.O. Box 349
Augusta, ME 04332-0349
Telephone: (207) 512-3100
Toll-free: 1-800-451-9800
Fax: (207) 512-3285
TTY: (207) 512-3102

CONSENT FORM
AUTHORIZING RELEASE OF INFORMATION

Member Name: ______ ______ ______ ______ ______
Prefix First MI Last Suffix

Last Four Digits of Social Security Number: ______ Date of Birth: ______
mm dd yyyy

I authorize Maine Public Employees Retirement System (MainePERS) to obtain any and all information contained in the medical record from all treating providers and facilities (including copies of all applicable records) regarding any illness, injury, prescriptions, treatments, consultations and medical opinions relating to diagnosis, case and treatment of:
(LIST CONDITIONS HERE:) ______________________________
______________________________.*

ADDITIONAL AUTHORIZATION:
I ❑ do ❑ do not authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse, the diagnosis of psychiatric illness or information which refers to treatment of HIV and related diseases.

These disclosures are necessary to determine my eligibility, or continued eligibility, for disability retirement benefits from MainePERS. This consent will expire 12 months from the date of my signature below.

I understand that I may refuse authorization to disclose all or some health care information, and that my refusal may result in the denial of my application for benefits, or current eligibility for benefits, from MainePERS. I understand that this authorization may be revoked at any time by me. I understand that revocation may result in the denial of my application for benefits, or current eligibility for benefits, from MainePERS. In order to revoke, I would need to execute a written revocation, subject to the right of any person who acted in reliance on this authorization prior to receiving notice of the revocation. I understand that this authorization may be revoked by mailing or hand delivering a notice to that effect to the following address:

Disability Program, MainePERS, P.O. Box 349, Augusta, Maine 04332-0349

The revocation will be effective on the date received at MainePERS.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

I further authorize the release of any information obtained by MainePERS to any and all agents, servants, and employees of MainePERS acting on behalf of MainePERS in connection with my application, or appeal, for disability retirement benefits, including, but not limited to, consulting physicians, psychiatrists, psychologists and other health care providers, rehabilitation service providers, attorneys/advocates of MainePERS, Board Counsel and members of the MainePERS Board of Trustees.

A photocopy of this release will be as valid as the original. I understand that I am entitled to a copy of this authorization.

This release also grants the special authorization needed to release medical records pertaining to me under the Drug Abuse Office and Treatment Act of 1972 and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendment of 1974.

______________________________ ______________
Signature Date

***NOTE TO HEALTH CARE PROVIDERS:** It is important to realize that any information you send to us, including your office notes, may be released to the person executing this authorization or to his or her representative, upon request. Disclosure might occur, for example, if the record you send us is considered in connection with an application for disability retirement benefits and during any appeal proceedings, particularly those appeal proceedings which are open to the public. If you have reason to believe that the release of the information you send us might be harmful to the person executing this authorization in any way, or if you have another basis upon which complete confidentiality should be maintained, you must state so in a letter included with the records sent to the attention of the Disability Program. Your letter should clearly and fully inform us why the information should not be disclosed. Please note that form language stamped on or attached to the information prohibiting redisclosure will not be sufficient to maintain the complete confidentiality of the records.

P.O. Box 349
Augusta, ME 04332-0349
Telephone: (207) 512-3100
Toll-free: 1-800-451-9800
Fax: (207) 512-3101
TTY: (207) 512-3102

OPTIONAL

CONSENT FORM DESIGNATING AUTHORIZED REPRESENTATIVES

Employee Name:

Prefix	First	MI	Last	Suffix

Social Security Number: ____________

I hereby authorize Maine Public Employees Retirement System (MainePERS) to discuss or release any and all information pertaining to the following categories (if checked) to the representative(s) designated below:

- ☐ disability application or review (including relevant medical information)
- ☐ survivor benefit
- ☐ group life insurance (including relevant medical information)
- ☐ employment information including wages and personnel records
- ☐ retirement or refund application
- ☐ MaineSTART
- ☐ benefit information
- ☐ other (specify):____________

Note any special instructions pertaining to the discussion or release of the above information:

____

____

Designated Representative(s)

1. Name: ____________ Relationship: ____________

   Mailing Address: ____________

   Telephone Number: ____________

2. Name: ____________ Relationship: ____________

   Mailing Address: ____________

   Telephone Number: ____________

Notwithstanding the use of the word "Representative," this consent form is only for the purpose of authorizing employees of MainePERS to discuss and release information to the above individuals, and does not, in and of itself, authorize those individual(s) to make decisions on my behalf.

I understand that this authorization may be revoked by me at any time. In order to revoke, I need to execute a written revocation, subject to the right of any person who acted in reliance of this authorization prior to receiving written notice of the revocation. I understand that this authorization may be revoked by mailing or hand delivering a notice to that effect to the following address:

MainePERS, P.O. Box 349, Augusta, ME 04332-0349

Any revocation should indicate whether or not it applies to a specific representative or to all representatives listed on this form. Unless otherwise specified, the revocation will be applied to all the representatives listed above.

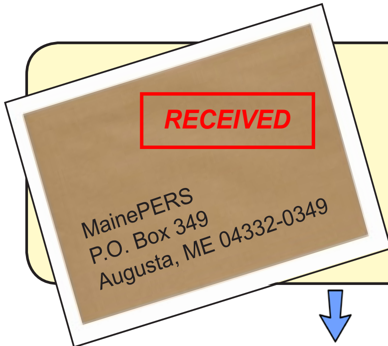
This consent shall expire 12 months from the date of my signature below.

Signature: ____________ Date: ____________

Disability Application Flow Chart

Complete an *Application for Disability Benefits*

You can call MainePERS, come in to our office or download an application at www.mainepers.org.



Application Received

When your completed application is received at MainePERS, it is assigned to a Disability Specialist.

Information Request

We request information from your medical providers and your employer(s). This includes talking to your supervisor(s) about your job duties.

Phone Interview

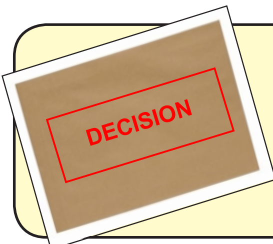
A MainePERS Disability Specialist contacts you to obtain detailed information, explain the application process and answer any questions.

Recommendation for Decision

Based on a thorough review of all information received, the Disability Specialist makes a recommendation for decision regarding your eligibility for a benefit.

Supervisory Review

The Disability Supervisor reviews your file for consistency with the Laws and Rules.



Decision Issued

A Disability Specialist contacts you regarding the decision on your eligibility for benefits and discusses the next steps in the process. MainePERS also mails you information.

Disability Retirement Checklist

Before Maine Public Employees Retirement System (MainePERS) can review your application for a disability retirement benefit, the following forms and documents need to be completed. MainePERS staff is available to help you complete the documents necessary to apply. For assistance, contact the Disability Unit at 207-512-3170 or toll-free at 1-800-451-9800. Return your completed forms directly to MainePERS at:

Maine Public Employees Retirement System (MainePERS)
P.O. Box 349
Augusta, ME 04332-0349

- [ ] **1. Application for Disability Retirement**

Answer all the questions on the application. If you have been out of work for more than two years, include copies of tax returns and all supporting documents for each year you have been out of work.

- [ ] **2. Consent Form Authorizing Release of Information**

Complete this form so we may obtain information from your medical providers.

- [ ] **3. Designated Representative (Optional)**

Complete this form if you would like someone other than yourself to be able to contact us on your behalf regarding your application.

- [ ] **4. Verification of Worker's Compensation and/or Social Security**

- If any of the condition(s) you are applying for are the result of an injury or accident received in the line of duty, provide proof of your application for Workers' Compensation benefits.
- If an employer that is also covered under the United States Social Security Act employs you, provide proof of your application for those benefits with your disability application.