



Attachment A

Disability Retirement Application Process

Purpose

In the event a Member of the City of Austin Employees' Retirement System (COA ERS) becomes disabled, he or she may be entitled to disability retirement benefits. This "Disability Retirement Application Process" packet should be completed by Members applying for disability retirement benefits in compliance with COA ERS' governing Statute, Article 6243n, Tex. Rev. Civ. Stat.

Eligibility Requirements

To be eligible for disability retirement benefits with COA ERS, 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 COA ERS unless the disability is the direct result of an on-the-job injury/illness with the employer (City or COA ERS) subsequent to the Member's 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 your responsibility to contact your City department and confirm your date of termination.*

Employees are encouraged to check with their disability insurance provider (e.g. Long Term Disability coverage) to determine how disability retirement from COA ERS 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 in the process as possible in order to establish a date in 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 as soon as possible to avoid delays in the application/review process.

Documentation Requirements

It is ***required*** that Members submit the following documents to COA ERS regarding their disability retirement application:

- COA ERS' *"Disability Retirement Application – Member's Statement"* (see Attachment A.1.). The original Member's Statement must be signed and sworn to by you before a Notary Public. 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.
- COA ERS' *"Physician's Statement on Disability"* (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.
- *NOTE:* If a physician does not feel it is appropriate for him/her to complete the physician's statement, copies of **all** of your medical records must still be submitted.
- 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 a full and complete notarized application packet. The content of any application and the evidence and documentation submitted in support of the application shall be your sole responsibility, including the expense of obtaining and providing physician statements and copies of all medical records from all treating physicians. Copies of medical records provided to COA ERS become the property of COA ERS. In addition, please be advised that you may be requested to

provide additional information and/or obtain examination(s) by a physician(s) as determined by the Disability Committee/Board.

Disability determination will be based on your mental or physical incapacitation as of the date of your application 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 considered in 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 failed to 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 COA ERS by mailing to:
City of Austin Employees' Retirement System
418 E. Highland Mall Blvd.
Austin, TX 78752-3720

Disability Retirement Application Process

All documents filed with COA ERS will be held in the strictest confidence permitted under the law. Once received, the application forms and supporting documentation will be evaluated by COA ERS' independent Medical Consultant. The Medical Consultant will submit a written opinion to COA ERS' Board of Trustees advising if, in his/her professional opinion, your disability condition meets the definition of disability as defined in COA ERS' governing Statute, Article 6243n.

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. Applicants are encouraged, but are not generally required, to attend the meetings. The Board Chair may, but is not required to, schedule a special meeting of the Board to consider new applications upon receipt of a written request from the applicant.

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 COA ERS 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 COA ERS 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 the 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 is 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 Disability Committee and/or Board have the right to request financial reviews and order examinations of any Member on disability retirement until the Member reaches the normal retirement age (currently age 62 or age 55 with 20 years of service).



City of Austin Employees' Retirement System

Attachment A.1. Disability Retirement Application Member's Statement

NOTE: This statement must be made by the Member. A person having a Power-of-Attorney or Guardianship for the Member 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. **ORIGINAL FORMS WILL ONLY BE ACCEPTED IF LEGIBLE. Any corrections must be initialed.**

Member's Full Name (First, Middle Initial, Last)	Social Security Number
Address (number and street)	City _____ State _____ Zip Code
Daytime Phone Number ()	Date of Birth
Current Height Current Weight	City Department Where You Work/ Worked:
Date of Hire	Last or Current Position

1. Job description (specific activities): _____

2. Last day worked due to disability: _____
3. List all previous adult work experience: _____

4. Indicate your education and training:

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

5. Describe your medical problem(s), including at least:
- 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/Dates: _____

6. Have you previously applied for disability retirement with the City of Austin Employees' Retirement System? Yes No
 If yes, when? _____
7. If your disability is job related, describe how you were injured and when: _____

8. Do you feel your condition is getting worse, is stable, or is improving?
 Please explain: _____

9. List activities (home or elsewhere) that you participate in now: _____

10. Have you engaged in or applied for any employment other than with the City of Austin during the past year? Yes No
 Please explain. _____

11. Have you undergone or are you currently participating in vocational/physical therapy rehabilitation? Yes No
 If yes, explain. _____

12. Have you undergone or are you currently participating in any job or vocational training? Yes No
 If yes, explain. _____

13. List ALL physicians consulted for **this** medical problem and 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

14. 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 from each of these physicians.*):

Name	Mailing Address	Diagnosis	Date

15. List all hospitalizations and operations:

Hospital	Treatment or Operation	Date

16. 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

17. Have you followed all of your doctor's recommendations? Yes No

If no, explain: _____

18. City of Austin Employees' Retirement System (COA ERS) 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

NOTE: 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 your responsibility to contact your City department and confirm your date of termination.

b. How long do you expect your disability to continue? _____

c. What improvement is expected relative to your disability? _____

19. The COA ERS 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

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

I, the undersigned, do hereby make and file this report and 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 binding any physician 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 description and personnel history; I also authorize the release of my employer's medical/confidential 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 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

Subscribed and sworn to before me by the said Member this _____ day of _____, 20_____.

My commission expires_____. _____

Notary Public Signature



City of Austin Employees' Retirement System

Attachment A.2. Physician's Statement on Disability

MEMBER INFORMATION (<i>NOTE: This top section <u>must be completed by the Member</u> prior to the statement being given to the treating physician.) Original statements must be submitted from a M.D. (family practitioner or medical specialist) or D.O. (osteopathic medicine).</i>	
Member's Full Name	Social Security Number
	Age:
<u>REQUEST AND LEGAL RELEASE FROM MEMBER:</u> I am applying for permanent disability retirement from the City of Austin Employees' Retirement System. Please furnish me a <u>complete</u> copy of my medical records, including all notes, narrative reports, and test results, to accompany this Physician's Statement.	
_____ Member's Signature	_____ Date
Name of Attending Physician	Address
Physician's Area of Expertise or Specialty	Board Certification (List all applicable certifications)

<u>NOTE TO PHYSICIAN:</u> 1. We honor and appreciate your opinion. 2. You are not asked to decide if your patient is "disabled or not". Statutory guidelines make that determination. 3. We need your supporting evidence of disease/injury and its severity and appreciate your professional opinion on the matter. A copy of the full chart is required. 4. This data is necessary to determine your patient's disability status according to provisions of the City of Austin Employees' Retirement System's (COA ERS) Act. THANK YOU for your consideration. <div style="text-align: right;"> R.A. Dennison, M.D. Independent Medical Consultant City of Austin Employees' Retirement System </div>

1. Diagnosis of Disability (not Dx codes):

2. a. Date of onset: _____
b. First visit for 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 other significant 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): _____

6. Describe physical limitations of patient: _____

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

8. 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

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

10. In your opinion, is your patient able to be employed in some sedentary work activity? Yes No

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

Diagnosis	Dates

12. In your opinion, is this patient competent and capable of handling his/her own personal and financial affairs? Yes No

13. Has this patient been compliant with your care and advice? Yes No

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

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)