PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction
Member's Application for Disability Retirement
Form Last Revised: February, 2020

Before you file an application for a disability retirement allowance, please note that you should:

- Contact your retirement board. This is an important step in ensuring that you have all of the information that you need. The staff at your retirement board will help you understand the process and respond to your questions throughout the process.

Read the *Guide to Disability Retirement for Public Employees*

- *www.mass.gov/perac*
- This guide will give you general information about the disability process. Your retirement board can furnish you with a copy of this guide.

Next Step

- Be sure to complete the entire application, including the release forms, and attach all required documents before returning your application to your retirement board. If your application is incomplete, the application process will be delayed. Until all of the required information has been submitted, your retirement board cannot assign a date of application, which will be very important in determining your effective date of retirement and retirement allowance date.
- Your retirement board can prepare an estimate of your retirement allowance for planning purposes at any time, but an official retirement allowance cannot be calculated until your application has been approved. If your application is approved, you may need to submit additional documents, including, if applicable, your marriage certificate, your spouse's birth certificate, and your dependent children's birth certificates.
- Before you send your application and your documents to your retirement board, make a photocopy of them for your own records.

Your Retirement Board Will:

- Request information from your employer, your personal physician, and the other physicians, hospitals, and insurance companies that you identified on your application.
- You may, if you wish, submit the Physician's Statement to your primary treating physician. If you choose to do so, let your retirement board know so that duplication of effort can be avoided.

Next Step

- When all the information specified above has been received by your retirement board, the application package is considered complete and your retirement board will decide whether to ask the Public Employee Retirement Administration Commission (PERAC) to set up a three member regional medical panel to examine you.

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Timeframes

- The regional medical panel should meet within 60 days of being appointed by PERAC to conduct its examination.
- You will be given a 14 day notice of the scheduled examination(s).
- The regional medical panel will report their findings and recommendations to PERAC within 60 days after completing their examination(s).
- Within 5 days of receipt of a properly completed medical panel report, PERAC will forward the report to your retirement board.
- Your retirement board has the option at this point of requesting further information or a clarification from the regional medical panel if they determine that it would be helpful.
- Within 30 days of receipt of the report, your retirement board will notify you of the panel's findings and provide you with a copy of all of the documents completed by the regional medical panel.
- If the regional medical panel precludes retirement for the disability you claimed, your retirement board could either deny your application or it could ask PERAC for a new regional medical panel if the board believes that circumstances warrant it.

  If PERAC declines to schedule a new examination, your board will deny your application.
- If the regional medical panel findings permit retirement for the disability claimed, your retirement board shall determine whether or not to approve the application.
- A hearing may be held on any disability retirement application and shall be held upon your request.
- If a hearing is scheduled, your board must give you at least a 30 day notice of the time and place for the hearing and the issues involved.
- Your retirement board's decision about your eligibility for disability retirement must be made no later than 180 days after you file your completed application, unless PERAC grants an extension.
- If your application is approved by your retirement board, it will be transmitted to PERAC for final action. PERAC must act on your application within 30 days of its receipt.
- If your application is denied by your retirement board, your retirement board will advise you of your right to appeal the decision.

Member's Application for Disability Retirement

Form Last Revised: February, 2020

Retirement Board: Please place your address, phone number, fax number and email address here.

Name of Retirement Board:	MWRA Employees' Retirement Board		
Address:	2 Griffin Way		
City/Town:	Chelsea	**Zip Code:**	02150
Telephone:	(617) 305-5595	**Fax:**	(617) 371-1616

Applicant's Information

Applicant's Full Name (First, Middle Initial, Last) | **Former or Maiden Name** (if different)

Street Address | **Social Security # (last four)** ***-**-__ __ __ __

City/Town | **State** | **Zip Code** | **Phone #**

Email

Date of Birth | **Place of Birth**

Sex ☐ **M** ☐ **F** **Are You a Veteran?** ☐ **YES** ☐ **NO**

If you will be residing at an address other than the one above (for example, a summer or retirement address) within the next 12 months, please list your alternate address below.

Alternate Street Address

City/Town | **State** | **Zip Code** | **Phone #**

To: | **From:**

Dates in Residence at Alternate Address (Fill in To/From Above)

I understand that I have the right to apply for Accidental Disability and/or Ordinary Disability Retirement benefits. If I believe my disability may be the result of a job-related incident or injury, I may apply for Accidental Disability benefits and must answer all of the questions on this application. I will be required to provide evidence that my disability occurred as a result of a personal injury sustained or a hazard undergone while in the performance of my duties at a definite place and time without serious and willful misconduct on my part.

If I apply for Accidental Disability Retirement and PERAC approves my application after considering the Retirement Board's findings, the Regional Medical Panel Report and other evidence, I will be granted an Accidental Disability.

If I apply for an Accidental Disability and PERAC approves an Ordinary Disability application for me based on the Retirement Board's findings, the Regional Medical Panel Report and other evidence, then I may be retired for Ordinary Disability.

I apply to be retired on the basis of:
(Fill in the blank below with **ONE** of the following: **ACCIDENTAL, ORDINARY,** or **EITHER** for Accidental or Ordinary Disability)

I sign this application under the penalties of perjury. I affirm that the information presented in this application is correct, complete and accurately presented. I understand that giving false or incomplete information on this application may subject me to loss of my benefits as well as civil and criminal penalties.

Applicant's Signature: **Date:**

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-___ ___ ___ ___

Statement of Applicant's Duties

In order to receive a disability retirement allowance, a member must be permanently and totally disabled from performing the essential duties of his/her position. Essential duties are those duties or functions of a job or position that must necessarily be performed by an employee to accomplish the principal object(s) of the job or position. In accordance with PERAC's regulations, 840 CMR 10.07, your employer is required to identify the essential duties of your position.

1. Please state the medical condition(s) for which you are filing this application for disability retirement.

2. What is your current position and job title?

3. Is this a temporary or accommodated position?

4. Please describe the duties that you are required to perform in your current position.

5. How frequently are you required to perform these duties?

6. Please describe the duties that you are unable to perform as a result of your disability.

7. When did you cease to be able to perform all of the essential duties of your current position?

Member's Application for Disability Retirement

Disability Type: ______ **Member:** ______ **SSN:** ***-**-__ __ __ __

Your Employment History

Your Current Position (From which you plan to retire)

Title	**Name of Department**		
Employer's Street Address		**Name of Head of Department**	
City/Town	**State**	**Zip Code**	**Employer's Email Address**
Phone #	**Fax #**	**Dates Employed** (Fill in From/To above) **From:** **To:**	

Your Previous Positions

Please list all previous employment, beginning with your most recent position. Include all prior public and private employment. Please note that, if any other Massachusetts agency or unit has ever employed you, you may be eligible to purchase creditable service for that public sector employment. Contact your retirement board for further information about making such a purchase. If you need additional space, please attach a separate sheet.

Employer's Name	**Dates Employed** (Fill in From/To above) **From:** **To:**		
Street Address	**City/Town**	**State**	**Zip Code**
Employer's Name	**Dates Employed** (Fill in From/To above) **From:** **To:**		
Street Address	**City/Town**	**State**	**Zip Code**
Employer's Name	**Dates Employed** (Fill in From/To above) **From:** **To:**		
Street Address	**City/Town**	**State**	**Zip Code**
Employer's Name	**Dates Employed** (Fill in From/To above) **From:** **To:**		
Street Address	**City/Town**	**State**	**Zip Code**
Employer's Name	**Dates Employed** (Fill in From/To above) **From:** **To:**		
Street Address	**City/Town**	**State**	**Zip Code**

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Statement About Recent Physical Activities

1. For the period of the last year, please describe your physical activities, including:
   - Medical rehabilitation activities
   - Activities of daily living (for example, driving, cleaning, etc.)
   - Sports or other strenuous activities
   - Other employment since the onset of your disability

G.L. c. 32, § 15

1. Have you been officially investigated for or charged with misappropriation of funds from your employer or convicted of any crime related to your office or position? **YES** ☐ **NO** ☐
   If **YES**, please provide documentation.

If you are only applying for ordinary disability, you are not required to complete the next section for accidental disability and can skip to page 10.

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Reason for Accidental Disability

One of the conditions for receiving approval of an application for accidental disability retirement is that your retirement board must find that your disability is the natural and proximate result of either a personal injury you sustained (usually, one or several specific incidents), or a hazard undergone (generally, exposure to a harmful situation over a period of time).

Certain employees may be eligible to apply for an accidental disability benefit under one of three statutory Presumptions described in Massachusetts General Laws, Chapter 32, Sections 94, 94A and 94B. Please direct your questions about your Presumptions to your retirement board.

Please identify the reason for your disability: **Personal Injury** ☐ **Hazard** ☐ **Presumption** ☐

In describing the personal injury that you sustained or the hazard to which you were exposed, it is important to be as specific as possible.

Medical Condition

1. Date(s):

2. Specific time(s) or if hazard, length of time exposed:

3. Location(s):

4. Description of Incident(s), Hazard, or if applicable, why you are applying under a Presumption:

5. Job duties you were performing at the time of the incident:

6. In your own words, what is the injury(s) sustained as a result of the described incident?

Other Conditions

1. Please describe any other circumstances, events, or physical conditions that contributed or may have contributed to your disability.

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-___ ___ ___ ___

Incident Reports

Please provide the following information ***about each person or agency*** with which you filed a report of the injury(ies) that you sustained or the hazard to which you were exposed.

Agency		Name (First, Last, Middle)	
Street Address		City	State / Zip Code
Phone #	Fax #	Email	Date You Filed Report

Agency		Name (First, Last, Middle)	
Street Address		City	State / Zip Code
Phone #	Fax #	Email	Date You Filed Report

(Attach additional sheets if necessary)

Witness Data:

For each witness to the incident(s) or hazard(s) that you've described, please provide the following information.

Name (First, Last, Middle)	Phone #	Relationship to You
Street Address	City	State / Zip Code

Name (First, Last, Middle)	Phone #	Relationship to You
Street Address	City	State / Zip Code

(Attach additional sheets if necessary)

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Other Actions Taken

As a result of the incident(s) or hazard(s) that you have described, have you filed a grievance pursuant to a collective bargaining agreement? If **"YES"**, please describe the status of your grievance. ☐ **YES** ☐ **NO**

Did your employer take any administrative or disciplinary action as a result of the Incident(s) or Hazard(s) you have described? If "**YES"**, please describe the current status of your litigation. ☐ **YES** ☐ **NO**

Is there now or has there been, any other litigation in any forum regarding the injury upon which this application is based? If **"YES"**, please describe current the status of your litigation. ☐ **YES** ☐ **NO**

Workers' Compensation

Have you applied for, or are you receiving, or have you received weekly Workers' Compensation benefits or a Workers' Compensation settlement related to your claimed disability? If **"YES"**, please describe the current status of your Workers' Compensation. ☐ **YES** ☐ **NO**

Section 111F Benefits

Have you received or are you receiving benefits, related to your claimed disability, pursuant to Massachusetts General Laws, Chapter 41, Section 111F? If **"YES"**, please describe the current status of your Section 111F Benefit. ☐ **YES** ☐ **NO**

Other Payments

Have you received any other payments, assault, injury, etc. as a result of the injury upon which this application is based? If **"YES"**, please describe the current status of these payments. ☐ **YES** ☐ **NO**

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Medical Treatment - Treating Physician

Your retirement board will request a statement certifying your disability status from the physician who is treating you for your disability. Please provide the following information about the physician who has provided you with treatment in connection with your disability.

Health Care Provider's Name		**Hospital/Facility**	
Street Address	**City**	**State**	**Zip Code**
Phone #	**Fax #**	**Email**	
From:		**To:**	

Dates of Treatment (Fill in From/To above)

Member's Application for Disability Retirement

Disability Type: ____ **Member:** ____ **SSN:** ***-**-__ __ __ __

Physicians, Hospitals and Medical Facilities

Please list all physicians, hospitals and medical facilities with which you have consulted for your claimed disability. In addition, please list any physicians, hospitals and medical facilities at which you have received any treatment for any other condition within the last five years.

Begin with your Emergency Room/Facility treatment regarding the injury claimed as the basis of your disability, followed by the most recent hospital or medical facility from which you sought a consultation or treatment.

If you need more space, you may attach additional sheets.

Name of Emergency Room/Facility

Facility Street Address		**City**	**State**	**Zip Code**
Phone #	**Fax #**	**Email**		
Reason for Visit		**Dates of Treatment** (Fill in From/To above) **From:**	**To:**	

Name of Physician or Facility

Facility Street Address		**City**	**State**	**Zip Code**
Phone #	**Fax #**	**Email**		
Reason for Visit		**Dates of Treatment** (Fill in From/To above) **From:**	**To:**	

Name of Physician or Facility

Facility Street Address		**City**	**State**	**Zip Code**
Phone #	**Fax #**	**Email**		
Reason for Visit		**Dates of Treatment** (Fill in From/To above) **From:**	**To:**	

Name of Physician or Facility

Facility Street Address		**City**	**State**	**Zip Code**
Phone #	**Fax #**	**Email**		
Reason for Visit		**Dates of Treatment** (Fill in From/To above) **From:**	**To:**	

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Attorney Information

If you are represented by an attorney in this disability retirement application process, please provide the following information so that we may contact him or her as necessary.

Name of Attorney		Name of Firm		
Street Address		**City**	**State**	**Zip Code**
Phone #	**Fax #**	**Email**		

Insurance Coverage

If you have any insurance that covers the incident(s) or hazard(s) that you have described, please provide the following information about each policy.

Name of Insurance Company		Policy # *(if known)*		
Insurance Co. Street Address		**City**	**State**	**Zip Code**
Phone #	**Fax #**	**Email**	**Type of Coverage**	

Name of Insurance Company		Policy # *(if known)*		
Insurance Co. Street Address		**City**	**State**	**Zip Code**
Phone #	**Fax #**	**Email**	**Type of Coverage**	

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

The following authorization and selection forms are attached to your application. Make sure that you complete each of these forms and return them to your retirement board along with the rest of your completed application:

- Your signed *Authorization for Release of Medical and Insurance Records*
- Your signed *Regional Medical Panel Selection Form*

If your application is approved, you may need to submit additional documents, including, if applicable:

- Your marriage certificate
- Your spouse's birth certificate
- Your dependent children's birth certificates
- Your birth certificate
- Your military form DD214, if applicable

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Authorization to Use or Disclose Protected Health Information

I hereby authorize:

(physician, hospital, insurance company, employer, other health/rehabilitation entity)

to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to Federal or State law protecting its confidentiality. Information released on this authorization, if redisclosed by the recipient, is no longer protected.

Patient Name **Date of Birth**

Street Address **City** **State** **Zip Code**

Information To Be Disclosed To (Please check one): ☐ **PERAC,** 5 Middlesex Avenue, Suite 345, Somerville, MA 02145

☐ **Retirement Board** (Enter address below)

Board Name:

Address:

City/Town: **State:** **Zip Code:**

Please check one below to authorize release of your complete medical record, or, use the lines below to stipulate any exceptions.

☐ Authorize Release of Complete Medical Record

☐ Authorize Release of Complete Medical Record with the following exceptions

Exceptions:

This form encompasses the following:

- Disability Retirement Application: (Massachusetts General Laws, Chapter 32, Sections 6, 7, 26, 94, 94A and 94B)
- Restoration to Service Evaluation (including rehabilitation): (Massachusetts General Laws, Chapter 32, Sections 8 and 26)
- Accidental Death Benefit: (Massachusetts General Laws, Chapter 32, Sections 9 and 100)

I understand I may revoke this authorization at any time by notifying the Retirement Board or PERAC in writing, unless action has already been taken in reliance upon this authorization, or during an appeal under the applicable law.

This authorization will expire upon final determination of my disability application and Comprehensive Medical Evaluation/ Rehabilitation/Restoration to Service process.

Signature of Patient or Legal Representative: **Date**

Printed Name of Patient or Patient's Rep.:

Relationship to Patient/ Authority to Act for Patient, if applicable:

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

About the Authorization to Use or Disclose Protected Health Information

All entries must be completed for this authorization to be valid.

Please note, Retirement Boards are not covered entities under the Health Insurance Portability and Accountability Act (HIPAA), however all information is treated in a confidential manner consistent with Federal and State privacy laws.

How This Information is To Be Used

Pursuant to Massachusetts General Laws, Chapter 32, Section 6, the Public Employee Retirement Administration Commission (PERAC) is responsible for appointing regional medical panels to evaluate members seeking Disability Retirement. During the application process the Retirement Board and PERAC may obtain, share, and disclose information as necessary to complete the Disability Retirement process.

Pursuant to Massachusetts General Laws, Chapter 32, Sections 8 and 26, PERAC is also responsible for conducting Comprehensive Medical Evaluations (CMEs), offering Rehabilitation, and scheduling Restoration to Service (RTS) examinations to determine if the member is able to perform the essential duties of his/her former position, with or without rehabilitation. During this process, the Retirement Board and PERAC may obtain, share, and disclose information as necessary to complete this evaluation process. The information used/shared/disclosed during the four phases of the Disability process may include information provided by physicians, hospitals, insurance companies, employer, and other health/rehabilitation entities.

Please note, this original authorization form may be copied and reissued for the purpose of gathering and sharing protected information necessary to the Disability Application, CME, Rehabilitation, and RTS examinations.

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Medical Panel Selection

Unless your retirement board denies your application as a result of an initial fact-finding hearing, you must have a regional medical panel examination. PERAC appoints all regional medical panels. When your retirement board determines that your application for disability retirement is complete, the board (which meets at least once each month) may petition PERAC to appoint a three-member state-financed independent regional medical panel to examine you.

No physician who has already examined you or treated you, except as part of a prior regional medical panel, can be appointed to a panel to examine you.

PERAC will schedule the regional medical panel examination(s) and notify you at least 14 days in advance of the date(s), time(s), and location(s).

Regional Medical Panel Selection Form

Three Separate Single Examinations or One Joint Examination

- You have the right to request three separate single physician examinations when you file your disability application.
- If you do not request separate single examinations at application filing time a joint panel can be convened.
- You may request separate examinations at any time prior to a joint examination date, but PERAC will not ordinarily consider requests for separate examinations less than 48 hours prior to a scheduled joint examination.

You must indicate whether you prefer one joint examination or three separate single examinations by checking one of the boxes below:

☐ I want to be examined by a joint regional medical panel.

☐ I want to be scheduled for three separate single examinations.

By signing, I acknowledge that if I fail to appear at the scheduled medical appointment(s), I will be required to reimburse the Commonwealth for the cost of the examination, prior to the scheduling of a new examination.

Signature of Applicant: **Date:**

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Addendum Sheet to the Member's Application for Disability Retirement

Please use this sheet to provide further information in the event that you find the space provided on the form to be insufficient. Please identify the question(s), by Page Number and Question Number, for which you are providing further information.