ERS OF ALABAMA

Disability Retirement Application Packet

State Employees - Part I

If your career is cut short because of permanent disability, you may qualify for monthly disability benefits.

PART I of the Disability Retirement Application Packet and the Report of Disability Packet are required to initiate the disability retirement process. Once we receive your completed Part I forms and your Report of Disability Packet, the RSA Medical Board will meet to determine eligibility (the first Tuesday of each month). If approved for disability, the ERS will send the Retirement Application Packet Part II. **The retirement process is not complete until you have returned the RSA Retirement Benefit Option Selection form in Part II.**

START TODAY

This document includes the following forms:

- **ERS Application for Disability Retirement**
- **ERS/JRF Insurance Authorization**
- **RSA Direct Deposit Authorization**

IMPORTANT INFORMATION

- The Disability Retirement Application Packet Part I and the Report of Disability Packet must be received at least 30 days and not more than 90 days prior to the effective date of retirement.
- The effective date of retirement must be the first day of a month.
- It is the responsibility of the member to ensure all forms are mailed to the RSA.

CONTACT US

Please contact Member Services at 877.517.0020 if you have any questions.

Make sure that the ERS has your current home mailing address. You can change your mailing address online at https://mso.rsa-al.gov or by completing the Address Change Notification form. Important information regarding your retirement will be mailed from time to time to your home mailing address.

FORM INSTRUCTIONS

1. Complete the first four sections of the **ERS Application for Disability Retirement**. Have your employer complete the Employer Certification section.
2. Complete the **ERS/JRF Insurance Authorization** form. **Please do not forget to sign this form where needed.**
3. Complete the first page of the **RSA Direct Deposit Authorization** form. Send this form to your financial institution to complete the second page. This form will authorize the ERS to remit and credit your benefit directly to your bank account and eliminate the possibility of your check being lost or stolen.
4. Send the **ERS Application for Disability Retirement**, **ERS/JRF Insurance Authorization**, and any other completed forms to:

   ERS
   P.O. Box 302150
   Montgomery, AL 36130-2150

The **Disability Retirement Application Packet Part I** and the **Report of Disability Packet** must be received by the ERS at least 30 days and not more than 90 days prior to the effective date of retirement. The effective date of retirement must be the first day of the month.

FREQUENTLY ASKED QUESTIONS

Q. How do I qualify for disability retirement?

To qualify for a disability benefit, the member must meet all of the following conditions: (1) The member must have 10 years of creditable service. (2) The member must be in-service. A member is considered in-service if currently working or on official leave of absence, with or without pay, for one year, which may be extended for no more than one additional year. A member will not receive service credit for periods of leave without pay. (3) The RSA Medical Board must determine the member to be permanently incapacitated for the further performance of duty. The Medical Board bases its determination upon information provided by the member's physician. The Medical Board normally meets on the first Tuesday in each month.

Q. How are disability benefits calculated?

Maximum monthly disability retirement benefits are calculated identically to those for service retirement, **except** that additional credit for sick leave cannot be converted to retirement credit.

Q. What is an annual disability review?

A disability retiree will be reviewed once each year for the first five years and once every three-year period thereafter until age 60 (age 52 for State Police) for Tier 1 Members and age 62 (age 56 for State Police and FLC) for Tier 2 Members to determine whether the retired member remains eligible for disability benefits.

If the Report of Disability Packet is being completed for the Annual Disability Review, the medical documentation provided by your physician must be based upon a current examination conducted within four months prior to submission of the forms to the RSA. The completed forms are to be returned to the RSA within 30 days of the initial request.

Q. How do I cancel my retirement application?

Should you desire to cancel your ERS Application for Disability Retirement, written notice must be given to the RSA prior to your effective date of retirement. Failure to give timely notice will result in an irrevocable application.

Questions?

- » Visit RSA's website at www.rsa-al.gov
- » Email ERS through the RSA website; click on the "Contact" link at the top of the page
- » Call ERS at 877.517.0020
- » Attend an ERS Retirement Preparation Seminar

ERS OF ALABAMA

ERS Application for Disability Retirement

Employees' Retirement System of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Your SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

Your Information

Name _____
First Middle/Maiden Last

Address _____
Street or P.O. Box City State ZIP Code

Telephone Number _____ Email Address _____

Date of Birth _____

Retirement Information

The Report of Disability Packet must also be submitted.

Employer _____

Date of Retirement _____ *(This date is always the first of a month.)*

A completed Direct Deposit Authorization must be submitted to the ERS to authorize remittance to the bank/financial institution.

Beneficiary Designation

Divorce or annulment of a marriage shall not revoke or void the designation of a spouse as beneficiary for any benefits payable by RSA.

The beneficiary to whom I should like to receive any benefit due at my death _____

Relationship to me _____ Sex ☐ Male ☐ Female

Social Security Number _____ Date of Birth _____

If the designated beneficiary listed above is different from that listed on my active account, make the change effective **(check one)**:
☐ Upon the submission of this signed and notarized application to the ERS.
☐ On the date of my retirement.

Member Authorization

Sign Here

Please have your signature acknowledged before a Notary Public.

Your Signature _____ **Date** _____

State of _____, County of _____

On this _____ day of _____, 20_____, personally appeared before me, the above named individual and acknowledged under oath that the statements made are true.

Signature of Notary Public _____ My Commission Expires _____

Employer Certification

To be completed by the employing agency

No contributions should be made on lump sum leave pay.

Notify ERS of any changes (e.g. contributions, etc.).

Last date of compensated employment _____

Date of Termination _____

Retiring Employee's Job Classification _____

Additional wages with date paid _____
(i.e. extra pay period, overtime, etc.)

Indicate/explain periods with no wages _____
(i.e. leave without pay, etc.)

Project/certify amount of wages for last 4 months for which contributions will be submitted:

Oct		Apr	
Nov		May	
Dec		Jun	
Jan		Jul	
Feb		Aug	
Mar		Sep	

Sign Here ➔ **Employer Signature** _____ **Date** _____

Telephone Number _____

ERS/JRF Insurance Authorization

Employees' Retirement System of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Your SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

Your Information

Name _____
First Middle/Maiden Last

Address _____
Street or P.O. Box City State ZIP Code

Telephone Number _____ Email Address _____

Date of Birth _____

Health Insurance Election

If you have any questions, please contact the State Employees' Insurance Board (SEIB) at 866.836.9737.

I wish to continue my insurance under the healthcare plan I have selected below, *(provided you have at least 10 years of creditable coverage with SEIB)*. I authorize monthly premium deductions from my retirement check until otherwise notified by me, or , in case of death, my beneficiary or other proper authority.

Select **Only One**: ☐ State Employees' Health Insurance Plan (BCBS) ☐ BCBS Supplemental ☐ Southland Optional Plan

I wish to **discontinue** my ☐ health coverage ☐ dental coverage

I wish to **discontinue** my dependent health insurance coverage for the individuals listed below:

First Name	Middle Name	Last Name	DOB	Sex	Relationship to Me

Credit Union Deductions

I authorize the Employees' Retirement System or Judicial Retirement Fund to deduct $ _____ from my monthly benefit payment and transmit the amount deducted to the following credit union.

☐ Alabama State Employees' Credit Union ☐ Alabama One Credit Union ☐ Guardian Credit Union

Miscellaneous Insurance Deductions

*Only available to **active** members who are applying for retirement*

Company Name	Policy Number	Monthly Premium

Sign Here → *Member*

Your Signature _____ **Date** _____

THIS BOX IS FOR ERS/JRF USE ONLY

Years of Service _____ Months of Service _____ Effective Date of Retirement _____

Type of Retirement ❑ Service ❑ Disability DROP Participant ❑ Yes ❑ No DROP Ended Date _____

RSA Direct Deposit Authorization

Retirement Systems of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Your SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

Direct Deposit from which System(s): ☐ TRS ☐ ERS ☐ JRF ☐ PEIRAF ☐ RSA-1 *(Annual or Monthly Distribution Only)*

Your Information

No initials please

Indicate below **Your SSN** *the system(s) from which you would like your benefit(s) direct deposited.*

Name _____
First Middle/Maiden Last

Address _____
Street or P.O. Box City State ZIP Code

Telephone Number _____ Email Address _____

Date of Birth _____

Check One: ☐ Retiree ☐ Beneficiary of Deceased Retiree or Member

If you are a beneficiary, please provide the following for the deceased retiree or member.

Name _____ SSN _____

Account Holder Certification

I agree to notify the Retirement Systems of Alabama (RSA) immediately of the death of the recipient of the retirement benefits being deposited to this joint financial institution account, and to return all payments to the RSA that are deposited to this account after said death. The RSA will determine and pay any survivor benefits. The RSA is authorized to make necessary debit entries to this joint account for any credits that were made in error.

Joint Financial Institution Account Holder(s) Name(s)	Joint Financial Institution Account Holder(s) Signature(s)
_____	_____
_____	_____
_____	_____

Date _____

Signature Certification

Each benefit payment is to be credited to my account at the financial institution specified on the reverse side of this form and such payment will be in full payment, satisfaction, and discharge of the amount then falling due and payable to me on account of such payments.

If my death occurs prior to the due date of any payment made by the RSA in compliance with this request or if adjustments are required for any credit entries to my account, I authorize the RSA to make the necessary debit entries to my account. I hereby reserve the right to revoke or cancel this request, such revocation or cancellation to take effect within 30 days of receipt of written notice by the RSA.

I authorize my payment to be sent to the financial institution named on the reverse side of this form to be deposited to the designated account.

Sign Here → **Your Signature** _____ **Date** _____

Note: The retiree or beneficiary of a deceased retiree or member must complete this page.
Then take or mail both pages to your financial institution to verify your information.
Your financial institution must complete the second page and agree to the Master Agreement.

RSA Direct Deposit Authorization

This page to be completed by a representative of the financial institution.

Name _____ **SSN** ___ ___ ___ ___ ___ ___ ___ ___ ___

Financial Institution Information

Depositor Account No _____ Bank Routing No _____

Financial Institution Name _____ Type of Account ☐ Checking ☐ Savings

Mailing Address _____
Street or P.O. Box City State ZIP Code

Name(s) of Person(s) on this Account _____

_____

_____

Financial Institution Certification

MASTER AGREEMENT

In accordance with the provisions of Section 3.6.4 of the 2012 National Automated Clearing House Association (NACHA) Operating Rules and Guidelines, both the Retirement Systems of Alabama (RSA), as the Originator, and the above named Financial Institution consider the following to be the Master Agreement, as defined by the NACHA Operating Rules and Guidelines, and agree that it is to be applicable to all payments sent by the RSA to the Financial Institution for the benefit of all benefit recipients having accounts with the Financial Institution.

In consideration of the RSA making benefit payments in accordance with this Direct Deposit Authorization without requiring proof that the retiree/beneficiary identified on this form is alive on the date on which such benefits are paid and are credited to his or her account, the Financial Institution agrees to repay and refund to the RSA, on demand, the full amount of any payments made to and received by the Financial Institution after the date of death of the benefit recipient, regardless of whether the account listed on this Direct Deposit Authorization contains sufficient funds for the refund. The Financial Institution further agrees to accept the certification of the RSA as to the date of death of such payee as sufficient evidence in accordance with Section 2.10 of the 2012 NACHA Operating Rules and Guidelines.

I, the undersigned, confirm that the identity of the above named retiree/beneficiary, account number, and type are true and accurate. As the representative of the above named Financial Institution, I certify that the Financial Institution agrees to receive and deposit the identified payments in accordance with the Master Agreement and pursuant to Section 3.6.4 of the 2012 NACHA Operating Rules and Guidelines, and that the Master Agreement is applicable to all payments sent by the RSA to the Financial Institution for the benefit of the retiree/beneficiary.

Representative Name_____

Sign Here ➔ *Financial Institution*

Representative Signature _____ **Date** _____

Telephone Number _____

Please return completed form to:

The Retirement Systems of Alabama
P.O. Box 302150
Montgomery, AL 36130-2150
Fax: 334.517.7001

Note: Properly completed Direct Deposit Authorization forms received by the RSA before the 13th of each month will be effective for the current month.

Report of Disability Packet

If your career is cut short because of permanent disability, you may qualify for monthly disability benefits.

This packet contains the information and forms you need to initiate the disability retirement process. Once we receive your completed Report of Disability Packet and Disability Retirement Application Packet Part I, the RSA will send the Retirement Application Packet Part II. **The retirement process is not complete until you have returned the RSA Retirement Benefit Option Selection form in Part II.**

START TODAY

This document includes the following forms:

» **Part A: Statement by Examining Physician**

» **Part B: Applicant Authorization**

IMPORTANT INFORMATION

» The Statement by Examining Physician and your Disability Retirement Application Packet Part I must be received at least 30 days and not more than 90 days prior to the effective date of retirement.

» The effective date of retirement must be the first day of a month.

» It is the responsibility of the member to ensure all forms are mailed to the RSA.

CONTACT US

Please contact Member Services at 877.517.0020 if you have any questions.

Make sure that the RSA has your current home mailing address. You can change your mailing address online at https://mso.rsa-al.gov or by completing the Address Change Notification form. Important information regarding your retirement will be mailed from time to time to your home mailing address.

Retirement Systems of Alabama
P.O. Box 302150 • Montgomery, Alabama 36130-2150 • 877.517.0020 • 334.517.7000 • www.rsa-al.gov

September 2019

FORM INSTRUCTIONS

1. Have your physician complete the **PART A: STATEMENT BY EXAMINING PHYSICIAN** after he/she has examined you. The form must be based upon a current examination conducted within four months prior to your effective date of retirement.
2. Complete the **PART B: APPLICANT AUTHORIZATION** form. The completed and signed form will authorize your physician to provide medical documentation to the RSA.
3. Send the **PART A: STATEMENT BY EXAMINING PHYSICIAN**, and any other completed forms to:

   RSA
   P.O. Box 302150
   Montgomery, AL 36130-2150

The **STATEMENT BY EXAMINING PHYSICIAN** and your **DISABILITY RETIREMENT APPLICATION PACKET PART I** must be received at least 30 days and not more than 90 days prior to the effective date of retirement. The effective date of retirement must be the first day of a month.

FREQUENTLY ASKED QUESTIONS

Q. How do I qualify for disability retirement?

To qualify for a disability benefit, the member must meet all of the following conditions: (1) The member must have 10 years of creditable service. (2) The member must be in-service. A member is considered in-service if currently working or on official leave of absence, with or without pay, for one year, which may be extended for no more than one additional year. A member will not receive service credit for periods of leave without pay. (3) The RSA Medical Board must determine the member to be permanently incapacitated for the further performance of duty. The Medical Board bases its determination upon information provided by the member's physician. The Medical Board normally meets on the first Tuesday in each month.

Q. How do I apply for disability retirement?

If the REPORT OF DISABILITY PACKET is being completed as verification of medical reasons for retiring on disability, it must be submitted with the DISABILITY RETIREMENT APPLICATION PACKET PART I. All packets are due to the RSA no less than 30 days and not more than 90 days before your effective date of retirement.

Q. How are disability benefits calculated?

Maximum monthly disability retirement benefits are calculated identically to those for service retirement, **except** that additional credit for sick leave cannot be converted to retirement credit.

Q. What is an annual disability review?

A disability retiree will be reviewed once each year for the first five years and once every three-year period thereafter until age 60 (age 52 for State Police) for Tier 1 Members and age 62 (age 56 for State Police and FLC) for Tier 2 Members to determine whether the retired member remains eligible for disability benefits.

If the REPORT OF DISABILITY PACKET is being completed for the Annual Disability Review, the medical documentation provided by your physician must be based upon a current examination conducted within four months prior to submission of the forms to the RSA. The completed forms are to be returned to the RSA within 30 days of the initial request.

Q. How do I cancel my retirement application?

Should you desire to cancel your APPLICATION FOR DISABILITY RETIREMENT, written notice must be given to the RSA prior to your effective date of retirement. Failure to give timely notice will result in an irrevocable application.

Questions?

- » Visit RSA's website at www.rsa-al.gov
- » Email RSA through the RSA website; click on the "Contact" link at the top of the page
- » Call RSA at 877.517.0020
- » Attend a Retirement Preparation Seminar or an individual counseling appointment

Report of Disability Part A: Statement by Examining Physician

Retirement Systems of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Your SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

Check One: ❑ TRS ❑ ERS

Applicant Information

For the application to be processed, all items must be completed.

Name _____
First Middle/Maiden Last

Address _____
Street or P.O. Box City State ZIP Code

Telephone Number _____ Email Address _____

Date of Birth _____ Sex ❑ Male ❑ Female

Job Classification_____ Blood Pressure_____ Height _____ Weight_____

Physician Statement

Medical examination must be conducted **within four months** *prior to the effective date of retirement or annual disability review date.*

This is to certify that the above named person has been under my professional care since _____ and was last
Month/Day/Year)

examined on _____ .
Month/Day/Year

Please list this patient's job requirements as described to you:

_____

_____

_____

_____

_____

In your professional opinion, by reason of the described condition, is the named applicant totally incapacitated for further performance of his/her duty? ❑ Yes ❑ No

If yes, list in detail the pathophysiologic diagnoses with supporting evidence for the diagnoses that cause the disability.

_____

_____

_____

_____

_____

In your professional opinion, is the named applicant's disability permanent? ❑ Yes ❑ No

If yes, list the objective findings that render the applicant permanently incapacitated to perform the normal functions of his/her duty.

_____

_____

_____

_____

_____

Report of Disability Part A: Statement by Examining Physician

Submit completed form to the Retirement Systems of Alabama

Name _____ **SSN** ___ ___ ___ ___ ___ ___ ___ ___ ___

Physician Statement Continued

Any person who makes a false statement or falsifies a record in an attempt to defraud the RSA shall be guilty of a misdemeanor, punishable by a fine up to $500 and/or imprisonment not to exceed one year.

Please list the patient's restrictions and reason for restrictions:

In your opinion, are there reasonable accommodations that could be made by the patient's employer to allow this patient to continue his/her employment? ❑ Yes ❑ No

If yes, list possible reasonable accommodations.

Remarks and/or records that clarify or support your diagnoses and findings.

Signature Certification

This application will not be processed until the form is completed in full and bears physician's signature.

Sign Here → *Physician*

Physician's Signature _____ **Date** _____

Original signature is required.

Physician Name _____

Address _____

Street or P.O. Box City State ZIP Code

Telephone Number _____ Physician Specialty _____

Disability Retirement Packet Part B: Applicant Authorization

Retirement Systems of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Your SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

Check One: ❑ TRS ❑ ERS

Your Information

Name _____
First Middle/Maiden Last

Address _____
Street or P.O. Box City State ZIP Code

Telephone Number _____ Email Address _____

Date of Birth _____

Physician Authorization

Physician Name _____

Physician Address _____
Street or P.O. Box City State ZIP Code

Authorization for Release of Information

I am applying for: *(check only one)*
❑ disability benefits from the Retirement Systems of Alabama (RSA)
❑ an annual disability review

Member Authorization

I am required to obtain from my treating physician medical information to support my claim for benefits. This information will be provided to the RSA Medical Board members for the purpose of determining my eligibility for benefits. I hereby authorize the release of my medical records to the RSA. Please mail the completed REPORT OF DISABILITY PART A: STATEMENT BY EXAMINING PHYSICIAN to the RSA at the above address.

Sign Here ➔ **Your Signature** _____ **Date** _____
Member