

Retirement System of Alabama

Report of Disability Packet

This packet includes the following documents:

- **Part A: Statement by Examining Physician**
- **Part B: Applicant Authorization**

The Statement by Examining Physician must be received at least 30 days and not more than 90 days prior to the effective date of retirement.



P. O. Box 302150
Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
www.rsa-al.gov

Report of Disability Packet Instructions

Read Carefully

Part A: Statement by Examining Physician

Statement by Examining Physician must be based upon a current examination conducted within four (4) months prior to your effective date of retirement. This Statement must be completed by your physician only after he/she has examined you.

Statement by Examining Physician must be submitted to the RSA no less than 30 days and not more than 90 days before your effective date of retirement. The effective date of retirement must be the first day of a month.

Part B: Applicant Authorization

Please complete Part B: Applicant Authorization. The completed and signed form will authorize your physician to provide medical documentation to the RSA.

Disability Retirement

To qualify for a disability benefit, the member must meet **all** 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.

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.

If the Report of Disability Packet is being completed as verification of medical reasons for retiring on disability, it must be submitted with the Retirement Application Packet Part I. All packets are due into the RSA no more than 90 days or less than 30 days prior to the designated retirement date.

Annual Disability Review

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 (4) 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.

Report of Disability
Part A: Statement by Examining Physician
 Retirement Systems of Alabama
 P. O. Box 302150 † Montgomery, Alabama 36130-2150
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Check One:

- ERS
- TRS

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

Name: _____ Soc. Sec. No.: _____

Address: _____ Sex: ____ Date of Birth: _____
(Street or P. O. Box)

(City) (State) (Zip + 4) Email Address _____

Home Phone: _____ Work Phone: _____ Blood Pressure _____ Height _____

Job Classification _____ Weight _____

This is to certify that the above named person has been under my professional care since _____ and
Month Day Year
 was **last examined** on _____. **Medical examination must be conducted within four (4) months**
Month Day Year
prior to the effective date of retirement or annual disability review date.

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 or No required) _____

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 or No required) _____

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

Name _____ Soc. Sec. No. _____

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? _____

Remarks and/or records that clarify or support your diagnoses and findings: _____

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

Any person who makes a false statement or falsifies a record in any attempt to defraud the Retirement Systems shall be guilty of a misdemeanor, and upon conviction, be punished by a fine up to \$500.00 and/or imprisonment not to exceed one year.

Physician's signature: _____ Date Submitted: _____
(Original signature is required.)

Physician's name (Type or Print): _____

Address: _____ Phone No.: _____
(Street or P. O. Box)

(City) (State) (Zip + 4) Physician Specialty: _____

Submit completed form to the Retirement Systems of Alabama.

Report of Disability

Part B: Applicant Authorization

Retirement Systems of Alabama

P. O. Box 302150 † Montgomery, Alabama 36130-2150

334-517-7000 or 877-517-0020

www.rsa-al.gov

Check One:

- ERS
- TRS

Member Name: _____

Soc. Sec. No.: _____

Date: _____
Month Day Year

Physician's Name: _____

Address: _____
(Street or P. O. Box)

(City) (State) (Zip + 4)

Authorization for Release of Information

I am applying for (check one):

- disability benefits from the Retirement Systems of Alabama
- an annual disability review

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. Therefore, I hereby authorize the release of my medical records to the RSA. Please mail the completed REPORT OF DISABILITY directly to the RSA at the above address.

Signature of Applicant: _____

Address: _____
(Street or P. O. Box)

(City) (State) (Zip + 4)

Home Phone: _____ Work Phone: _____