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.

CHANGE OF ADDRESS

Having your current mailing address on file with the RSA is very important.

» Please ensure your employer also has your current mailing address.

» Active members must change their address with their employer.

» After retirement, you may change your address online at https://mso.rsa-al.gov or by completing the Address Change Notification form.

» Important information regarding your retirement will be mailed to your current mailing address.

CONTACT US

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

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

June 2025

FORM INSTRUCTIONS

1. Have your physician complete the **PART A: STATEMENT BY EXAMINING PHYSICIAN** (must be **M.D or D.O.**) 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. What type of medical professional(s) can sign PART A: STATEMENT BY EXAMINING PHYSICIAN?

The actual original, handwritten signature of a Medical Doctor (M.D. or D.O.) is required. The lone signature of a Certified Registered Nurse Practitioner (CRNP), Physician's Assistant (PA/PA-C), Psychologist, Podiatrist, or Chiropractor is **not sufficient** and will **not** be accepted. Stamped, computer-generated, or copy services signatures are also **unacceptable**.

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 ❑ JRF

Applicant Information

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

Name _____
First Middle/Maiden Last

Mailing 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 contains the original handwritten physician's signature.

Sign Here → *Physician*

Physician's Signature _____ **Date** _____

Original signature is required. (Must be M.D. or D.O.)

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 ❑ JRF

Your Information

Name _____
First Middle/Maiden Last

Mailing 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 ➔ *Member*

Your Signature _____ **Date** _____