TEACHERS' RETIREMENT SYSTEM
OF THE CITY OF NEW YORK (TRS)
55 Water Street, New York, NY 10041
www.trsnyc.org • 1 (888) 8-NYC-TRS

For faster service and increased security, you may file your Tier IV Accident Disability Retirement Application online in the secure section of our website. Log in and go to **Electronic Forms**.

INSTRUCTIONS

PLEASE READ CAREFULLY

Before you complete this application, we strongly recommend that you read the *Accident Disability Retirement* brochure.

Filing Information

You may qualify for accident disability retirement if you satisfy the following requirements:

a) You are disabled due to an accident that was sustained in the performance of your duties in active service, and your accident was not caused by your own willful negligence. (Active service includes being on an approved leave of absence or having transferred-contributor status.)

b) You file your disability retirement application while in active service or within three months of the last date you were on active payroll; or, if you were on leave of absence without pay for medical reasons, you file the application within 12 months of the date you receive notice that you have been terminated.

c) You file a complete application for disability retirement, as defined below, and the TRS Medical Board determines that that you are disabled due to an accident according to the above standard.

If you believe that you are eligible for accident disability retirement, please complete the application and then, in the presence of a notary public, sign the application where required. You may mail this application to TRS, or someone acting on your behalf may file it at TRS' offices.

In order for your accident disability retirement application to be considered complete, TRS requires the following documents:

- ☐ "Tier IV Accident Disability Retirement Application" (AD4) [Contained in this document]
- ☐ "Applicant's Personal Report of Accident and Disability" [Contained in this document]
- ☐ "Authorization for Release of Health-Related Information" (DI47) [Contained in this document]
- ☐ "Report of Applicant's Physician" (DI32) [Contained in this document]
- ☐ Employer's accident report
- ☐ Medical records documenting the injury and the resulting disability (not exceeding 200 pages)

NOTE: Your application will be considered incomplete until we receive all of the components listed above. Incomplete applications will be archived after three months, and you must submit a new complete application to reactivate your filing for accident disability retirement.

Medical Board Evaluation

Once TRS has received all components of your application for accident disability retirement, we will contact you to schedule an interview and examination by the doctors on TRS' Medical Board. The Medical Board will determine your eligibility for accident disability retirement, and TRS will notify you of the Medical Board's decision within 5 days.

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Changing Information

You may change your payment option up to 30 days from the date your disability retirement application was approved or 30 days from your effective retirement date, *whichever is later*. Such changes become irrevocable at the end of the 30-day time period. Please note that the Applicant's Personal Report of Accident and Disability and the "Report of Applicant's Physician" may not be amended after they are filed.

You may change any information on your application after you have submitted it; TRS must receive your changes no later than one day before your effective retirement date — except for your payment option (see the previous paragraph). To make changes to your application, you may review your changes with a Member Services Representative online, using the chat feature in the secure section of our website.

Cancelling Your Application

If you decide not to retire under accident disability retirement, you may cancel your "Tier IV Accident Disability Retirement Application" by submitting a "Cancellation Request Form" (code MI5) or by submitting an equivalent request online. **TRS must receive this form at least one day before your meeting with the Medical Board, regardless of the date on which you mailed the form or the postmark date on the envelope**. Please note that you may **NOT** cancel your "Tier IV Accident Disability Retirement Application" after the Medical Board approves your disability retirement.

Denial of Your Application

Your accident disability retirement application may be denied if the Medical Board 1) does not deem you to be physically or mentally disabled at the time of your examination or 2) does not find that your claimed physical or mental disability was caused by the accident you reported on your accident disability retirement application. For information on how to appeal the Medical Board's decision, please see the *Accident Disability Retirement* brochure.

IF YOUR APPLICATION IS APPROVED

Electronic Fund Transfer

TRS requires bank account information from retiring members in order to pay their benefits directly by Electronic Fund Transfer (EFT). If TRS does not have account information to transmit your retirement allowance by EFT, or if there is an issue with your current account, your payments (including advance payments) will be delayed.

If you are currently paid on the City of New York payroll through direct deposit for work in a position that entitles you to TRS membership, you will be automatically enrolled to receive your monthly benefit payments (including advance payments) via EFT. You do not need to do anything; these payments will be automatically deposited in your account via EFT.

However, you would need to file an "EFT Election at Retirement Form" (code BK66) for any of the following scenarios:

- If you want your monthly benefit payments (including advance payments) to be deposited via EFT in a different account;
- If you are currently paid on the City of New York payroll through direct deposit for work in a position that does not entitle you to TRS membership (*e.g.*, substitute or per diem teacher); or
- If you are not currently paid on the City of New York payroll through direct deposit.

An online version of "EFT Election at Retirement Form" is located in the secure section of the TRS website. To avoid delays in receiving your benefit payments, you should file the "EFT Election at Retirement Form" along with your retirement application.

For more information, please see the *Electronic Fund Transfer* brochure, which is available on the TRS website.

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Age 55 Retirement Program Participants

If you are 62 or older at retirement, you may be eligible for the return of the *employee portion* of the Additional Member Contributions (AMCs) you made under this program, plus accrued interest. However, if you have an outstanding QPP loan balance that you do not repay before retirement, TRS will offset your loan balance against the AMC refund—resulting in a lower (or zero) AMC refund amount. If you qualify for a return of AMC funds, you will receive a separate payment from TRS; you do not need to take further action.

AMC refunds are eligible for rollover to an eligible Individual Retirement Arrangement or other successor program. In this case, you must file the "Application for Withdrawal of Additional Member Contributions at Retirement" (code RW116) and the "QPP Direct Rollover Election Form" (code RW29). Do not file these forms if you have an outstanding QPP loan.

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HOW TO COMPLETE THE TIER IV ACCIDENT DISABILITY RETIREMENT APPLICATION

In Part A: PERSONAL INFORMATION

All information must be provided.

In Part B: TDA ELECTION

If you are not a participant in TRS' TDA Program, you may skip this section.

If you are a participant in TRS' TDA Program, you will continue to maintain your account after you retire; this is sometimes called TDA Deferral status.

If you have **any open TDA loans**, you must continue to repay these loans during your retirement. You may repay your loan(s) through automatic deductions from your monthly retirement allowance (including any advance payments) or repay your outstanding loan(s) by making separate payments to TRS each month.

In Part C: RETIREMENT DATE ELECTION

Read the policy regarding how your effective retirement date is determined, then provide your initials in the space provided.

In Part D: PAYMENT OPTION ELECTION AND BENEFICIARY DESIGNATIONS

You must elect **ONLY ONE** payment option in Part D for your retirement allowance and designate beneficiaries if your payment option includes that provision. In all cases, you will receive your retirement allowance each month for as long as you live. If you want to provide for beneficiaries, you have several choices, each of which will reduce the amount of your monthly retirement allowance. For additional information, please see the *Retirement Payment Options: Tiers III/IV/VI* brochure.

When designating beneficiaries on this form, please provide their Social Security numbers (or alternative taxpayer ID numbers) and as much contact information as possible. This information will help TRS process any benefits that later become payable without unnecessary delay. If you want to designate additional beneficiaries, you can do so by completing the "Retiring Member's Additional Beneficiary Form" (code EN22) and filing it with your retirement application. Please note that you may designate a trust only for lump-sum payments.

Your payment options are categorized as follows:

Maximum Payment Option

Continuing Payment Options
- Option 1
- Option 2

Guaranteed Number of Payments Options
- Option 3 (5-Year Certain)
- Option 4 (10-Year Certain

Pop-up Options
- Option 5-1
- Option 5-2

If you elect a Continuing Payment or Pop-up Option:

- These options provide for one primary beneficiary only. You may not designate a trust or organization as your beneficiary.
- Your beneficiary's age is a factor in computing the amount of your monthly retirement allowance payments; **therefore, you must submit proof of your beneficiary's date of birth in conjunction with this application**.
- You must provide your beneficiary's Social Security number on your application. This information is needed for TRS to pay your beneficiary without delay when benefits become payable. We ask you to provide complete contact information for your beneficiary to aid in this process.

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In Part E: DESIGNATION OF BENEFICIARY FOR FRACTIONAL PAYMENT OF RETIREMENT ALLOWANCE AND DEATH BENEFIT #2

When designating beneficiaries on this form, please provide their Social Security numbers (or alternative taxpayer ID numbers) and as much contact information as possible. This information will help TRS process any benefits that later become payable without unnecessary delay.

Fractional Payment

You must designate a beneficiary to receive any fractional payment that may be due for the month in which you die. This fractional payment will be payable provided that you do not die on the last day of the month; the payment will be based on the number of days that you are alive during that month.

Death Benefit #2

You must also designate a beneficiary to receive Death Benefit #2, a lump-sum, post-retirement death benefit. The amount of this death benefit will be based on the death benefit in force on your retirement date (a maximum equaling three years' salary, subject to age reductions). The actual amount payable to your beneficiary will also depend on the amount of time between your retirement date and your death, as shown in the table below.

Year of Death After Retirement Date	Amount of Death Benefit #2
1st Year	50% of benefit in force on member's retirement date
2nd Year	25% of benefit in force on member's retirement date
3rd Year or later	10% of the death benefit in force on member's retirement date, or 10% of the benefit in force at age 60, whichever is greater

Please note the following about these two separate death benefits:

- If you want to designate more beneficiaries than space allows on this form, you may file the "Retiring Member's Additional Beneficiary Form" (code EN22) with your retirement application.
- The beneficiary you designate to receive your fractional payment or Death Benefit #2 benefit need not be the same beneficiary as you designate in Part D.
- If your beneficiary predeceases you, the fractional payment or Death Benefit #2 benefit will be made to your estate unless you designate another beneficiary for this payment.
- You may designate a person, organization, or trust as your beneficiary.
- You may change your fractional beneficiary designation at any time after you file this application by filing a "Designation of QPP Fractional Beneficiary Form" (code EN24).
- You may change your Death Benefit #2 beneficiary designation at any time after you file this application by filing a "Change of Beneficiary Form for the Post-Retirement Death Benefit under Death Benefit #2" (code EN34).

In Part F: AFFIRMATION OF UNDERSTANDING

You must sign and date the statement in the presence of a notary public, who must then complete Part G.

In Part G: NOTARIZATION

You must have this form notarized. The date in this notary section must be the same date that you enter in Part F.

ATTACHED FORMS

APPLICANT'S PERSONAL REPORT OF ACCIDENT AND DISABILITY

"AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION"

Please complete the Personal Report of Accident and Disability and the "Authorization for Release of Health-Related Information," sign and date them, and return them with your "Tier IV Accident Disability Retirement Application."

"REPORT OF APPLICANT'S PHYSICIAN"

Please have this form completed, signed, and returned to TRS by your physician.

Note: In addition to the above forms, which are contained in this document, you must also supply supporting medical records and an accident report from your employer. See page 1 for details on ensuring that your filing for accident disability retirement is complete.

TIER IV ACCIDENT DISABILITY RETIREMENT APPLICATION

TEACHERS' RETIREMENT SYSTEM
OF THE CITY OF NEW YORK (TRS)
55 Water Street, New York, NY 10041
www.trsnyc.org • 1 (888) 8-NYC-TRS

NOTE: Please print in black or blue ink, and initial any changes that you make on this application. For each selection that you make throughout this application, you must write your initials in the space provided and check the corresponding box.

PART A: PERSONAL INFORMATION

All information must be provided.

First Name | MI | Last Name | Social Security Number (last 4 digits only) XXX–XX–☐☐☐☐

Permanent Home Address | Apt. No. | TRS Membership Number

City | State | Zip Code | Primary Phone Number (Check one: ☐Home ☐Work ☐Mobile)

Personal Email Address | Alternate Phone Number (Check one: ☐Home ☐Work ☐Mobile)

Date of Birth (MM/DD/YYYY): ☐☐/☐☐/☐☐☐☐

☐ Check here if you entered new contact information above. TRS will then update our records based on what you entered.

Please keep your contact information up to date. You can visit our website to update your contact information anytime, or file a "Member's Change of Address Form" (code DM13) with TRS.

PART B: TDA ELECTION

If you are not a participant in TRS' TDA Program, you may skip this section.

If you are a participant in TRS' TDA Program, you will continue to maintain your account after you retire; this is sometimes called TDA Deferral status.

If you have **any open TDA loans**, you must continue to repay these loans during your retirement.
Please select below how to repay your loan(s).

___ ☐ *I elect to repay my outstanding loan(s) through automatic deductions from my monthly retirement allowance (including any advance payments).*

___ ☐ *I elect to repay my outstanding loan(s) by making separate payments to TRS each month.*

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PART C: RETIREMENT DATE ELECTION

If the TRS Medical Board approves your application, you will have the opportunity to elect a retirement date that is within 90 days of the approval date.

If TRS does not receive your election within 90 days of the approval date, TRS will default your retirement date to the later of a) the date you filed your accident disability retirement application or b) the day after the last day you were paid on payroll.

Please read the following statement, check the box, and provide your initials in the space provided.

____☐ *I have read and understand the above information about how my effective date of retirement will be determined. I understand that I cannot be on payroll as of my retirement date.*

PART D: PAYMENT OPTION ELECTION AND BENEFICIARY DESIGNATIONS

Please elect **ONLY ONE** of the payment options listed in Part D. Choose and complete any additional elections under your payment option. If you elect an option that provides a death benefit, you **must** designate a beneficiary in this part. **In addition, all options require a beneficiary for your fractional payment**.

If you need to designate additional beneficiaries (primary, contingent, or fractional), please file a "Retiring Member's Additional QPP Beneficiary Form" (code EN22) with this application.

For more information about the percentage of your retirement allowance that you can leave your beneficiaries, please see the *Retirement Payment Options: Tiers III, IV, and VI* brochure.

MAXIMUM PAYMENT OPTION

____☐ **Maximum Payment Option** Highest monthly retirement allowance, but does not provide a death benefit.

THEN *Go to **Part E** to designate a beneficiary for your fractional payment and for Death Benefit #2.*

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PART D (Continued)

GUARANTEED NUMBER OF PAYMENTS OPTIONS

	Payment to Beneficiaries
____☐ **Option 3 (5-year certain)**	Receives payments only if 60 payments have not been made before your death.
OR	
____☐ **Option 4 (10-year certain)**	Receives payments only if 120 payments have not been made before your death.

THEN *Designate your primary and contingent beneficiary below; then go to **Part E** to designate a beneficiary for a fractional payment and for Death Benefit #2.*

DESIGNATION OF PRIMARY BENEFICIARY

Beneficiary Name:	Percent (if applicable) ____%	*Check One:* Male ☐ Female ☐	Date of Birth: (MM/DD/YYYY)
Street:			Relationship:
City, State, Zip:		Beneficiary Soc. Sec. No.:	
Beneficiary Name:	Percent (if applicable) ____%	*Check One:* Male ☐ Female ☐	Date of Birth: (MM/DD/YYYY)
Street:			Relationship:
City, State, Zip:		Beneficiary Soc. Sec. No.:	
Beneficiary Name:	Percent (if applicable) ____%	*Check One:* Male ☐ Female ☐	Date of Birth: (MM/DD/YYYY)
Street:			Relationship:
City, State, Zip:		Beneficiary Soc. Sec. No.:	

DESIGNATION OF CONTINGENT BENEFICIARY

Beneficiary Name:	Percent (if applicable) ____%	*Check One:* Male ☐ Female ☐	Date of Birth: (MM/DD/YYYY)
Street:			Relationship:
City, State, Zip:		Beneficiary Soc. Sec. No.:	
Beneficiary Name:	Percent (if applicable) ____%	*Check One:* Male ☐ Female ☐	Date of Birth: (MM/DD/YYYY)
Street:			Relationship:
City, State, Zip:		Beneficiary Soc. Sec. No.:	

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PART D (Continued)

CONTINUING PAYMENT OPTIONS

Payment to Beneficiary

____☐ **Option 1** — Lifetime payments equal to 100% of your reduced monthly retirement allowance.

OR

____☐ **Option 2** — Lifetime payments equal to your choice of 75%, 50%, or 25% of your monthly retirement allowance.

Choose one of the following

____☐ 75%

____☐ 50%

____☐ 25%

OR

____☐ **Option 5-1 ("Pop-up" option)*** — Lifetime payments equal to 100% of your reduced monthly retirement payments.

OR

____☐ **Option 5-2 ("Pop-up" option)*** — Lifetime payments equal to 50% of your reduced monthly retirement payments.

**If beneficiary predeceases you, your payments increase to the maximum.*

THEN *Designate a beneficiary below, completing all contact information; then go to **Part E** to designate a beneficiary for a fractional payment and for Death Benefit #2.*

DESIGNATION OF BENEFICIARY

Beneficiary Name:	*Check One:* Male ☐ Female ☐	Date of Birth: (mm/dd/yyyy)
Street:		Relationship:
City, State, Zip:	Beneficiary Soc. Sec. No.:	
Phone No.:	Email Address:	

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PART E: DESIGNATION OF BENEFICIARIES FOR FRACTIONAL PAYMENT OF RETIREMENT ALLOWANCE AND DEATH BENEFIT #2 (All Payment Options)

Regardless of your election in Part D, you must designate a beneficiary to receive the fractional portion of your retirement allowance for the month in which you die, and you must also designate a beneficiary for Death Benefit #2.

DESIGNATION OF BENEFICIARY FOR FRACTIONAL PAYMENT

Beneficiary Name:	Percent (if applicable) ____%	*Check One:* Male ☐ Female ☐	Date of Birth: (MM/DD/YYYY)
Street:			Relationship:
City, State, Zip:		Beneficiary Soc. Sec. No.:	
Beneficiary Name:	Percent (if applicable) ____%	*Check One:* Male ☐ Female ☐	Date of Birth: (MM/DD/YYYY)
Street:			Relationship:
City, State, Zip:		Beneficiary Soc. Sec. No.:	
Beneficiary Name:	Percent (if applicable) ____%	*Check One:* Male ☐ Female ☐	Date of Birth: (MM/DD/YYYY)
Street:			Relationship:
City, State, Zip:		Beneficiary Soc. Sec. No.:	

DESIGNATION OF BENEFICIARY FOR DEATH BENEFIT #2

Beneficiary Name:	Percent (if applicable) ____%	*Check One:* Male ☐ Female ☐	Date of Birth: (MM/DD/YYYY)
Street:			Relationship:
City, State, Zip:		Beneficiary Soc. Sec. No.:	
Beneficiary Name:	Percent (if applicable) ____%	*Check One:* Male ☐ Female ☐	Date of Birth: (MM/DD/YYYY)
Street:			Relationship:
City, State, Zip:		Beneficiary Soc. Sec. No.:	
Beneficiary Name:	Percent (if applicable) ____%	*Check One:* Male ☐ Female ☐	Date of Birth: (MM/DD/YYYY)
Street:			Relationship:
City, State, Zip:		Beneficiary Soc. Sec. No.:	

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PART F: AFFIRMATION OF UNDERSTANDING

Please read the following statement and sign and date below in the presence of a notary. If you are an agent/legal representative signing on the member's behalf, please indicate this.

I understand that the filing of this application is irrevocable and cannot be withdrawn as of my initial payability date. I also affirm my understanding of the following:

- *ELECTRONIC PAYMENT: That TRS pays retirement benefits by Electronic Fund Transfer (EFT) and that my payments (including advance payments) may be delayed if TRS does not have bank account information on file for me.*

  *If I am currently paid on the City of New York payroll through direct deposit, I will be automatically enrolled in EFT. I also understand that I must file an "EFT Election at Retirement Form" (code BK66) to register my bank account information with TRS in the following circumstances: a) if I want my payments deposited in a different account; b) if I am not currently paid on the City payroll through direct deposit; or c) if I am currently paid on the City payroll in a position that does not entitle me to TRS membership (*e.g.*, substitute or per diem teacher).*
- *REQUIRED DOCUMENTATION: I must submit proof of my date of birth and, in some cases, my beneficiaries' dates of birth.*

  ☐ ***I have enclosed my employer's Accident Report.***

  ☐ ***I have enclosed medical records documenting my injury and the disability it caused.***
- *CHANGES AFTER FILING: I understand that any changes I chose to make to this form must be made no later than one day prior to my initial payability date, with the exception of the payment options and beneficiaries that I elected in Part D, which may be changed within 30 days after my initial payability date.*
- *OVERPAYMENT RECOVERY: If TRS determines that my retirement benefits from TRS are overstated, I am required to repay (or my beneficiaries may be required to repay) the resulting deficit amount in full, in accordance with TRS' applicable rules.*

  If my retirement allowance payments are transmitted electronically to my financial institution, I authorize and direct my financial institution to immediately refund any overpayments to TRS, including all payments made by TRS on or after the date of my death, and to charge the same to my bank account. TRS' certification of overpayment shall be sufficient evidence of an overpayment.

  If the funds remaining are not sufficient to permit my financial institution to fully refund overpayments by TRS, I authorize and direct my financial institution to provide to TRS all information related to the designated account, including withdrawals after the first of the month in which my death occurs, the names and addresses of all joint account holders and any individuals authorized to withdraw funds from the designated account, and any changes of address within one year prior to the date of my death.
- *RETURN OF ADDITIONAL MEMBER CONTRIBUTIONS (AMCs): I understand that, if I participated in the Age 55 Retirement Program and meet certain eligibility requirements, I may receive payment of the* ***employee portion*** *of my AMCs. I also understand that my payment of the employee portion of my AMCs may be used to offset any outstanding loans or deficits I may have. I authorize TRS to make this separate payment to me (or to roll over the payment to a successor program(s), if I so elect.*

☐ **CHECK HERE IF YOU ARE SIGNING AS AN AGENT**.

I affirm that, to the best of my knowledge, all information I have provided above is true and correct. If signing as an agent of the member named in Part A, I certify that I have no knowledge or notice that my authority as the agent has ended by revocation, termination, death, divorce, or otherwise.

YOUR SIGNATURE	YOUR PRINTED NAME	DATE (MM/DD/YYYY)

PART G: NOTARIZATION

TO BE COMPLETED BY A NOTARY (NOTE: Attestation made outside the U.S. must be executed before an American consul.)

State of _____)

) s.s.:

County of _____)

On the _____ day of _____, _____, before me personally appeared the

person known to me to be _____, the individual who executed the foregoing instrument and acknowledged to me that (s)he executed the same.

Signature: _____

Official Title: _____Expiration Date of Commission: _____

APPLICANT'S PERSONAL REPORT OF ACCIDENT AND DISABILITY

TEACHERS' RETIREMENT SYSTEM
OF THE CITY OF NEW YORK (TRS)
55 Water Street, New York, NY 10041
www.trsnyc.org • 1 (888) 8-NYC-TRS

Please Print

Applicant's Name

TRS Membership Number

Address

Primary Phone Number (Check one: ☐Home ☐Work ☐Mobile)

City

State

Zip Code

Alternate Phone Number (Check one: ☐Home ☐Work ☐Mobile)

Email Address

PART A: ACCIDENT REPORT

I am physically incapacitated for the performance of duties as a natural and proximate result of an accidental injury received while a member and while in the performance of such duties and not as a result of willful negligence on my part. The accident causing my disability occurred as follows:

Date (MM/DD/YYYY): _____ Time: _____

Location: _____

Conditions and description of your accident: _____

_____

_____

Result of accident: _____

_____

_____

Witnesses: _____

_____

_____

I was attended at or confined to: _____

_____

_____

From: (MM/DD/YYYY) _____ To: (MM/DD/YYYY) _____

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PART B: DISABILITY REPORT

I believe I am incapacitated and unable to remain employed in my present position because:

_____

_____

_____

_____

_____

_____

My physician, Dr. _____

(Give name in full.)

of _____, *advises me that*

(Give address.)

_____

_____

_____

_____

_____

_____

Signature: _____ Date (MM/DD/YYYY): _____

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

TEACHERS' RETIREMENT SYSTEM
OF THE CITY OF NEW YORK (TRS)
55 Water Street, New York, NY 10041
www.trsnyc.org • 1 (888) 8-NYC-TRS

This form authorizes release of medical information, including HIV-related information, to the Teachers' Retirement System of the City of New York (TRS) pertaining to filing for disability benefits. This authorization complies with the U.S. Department of Health and Human Services Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The information you provide may be protected from disclosure by federal and state privacy laws.

By initialing on page 2 where indicated and signing this form, you agree that medical information and/or HIV-related information may be provided to TRS and the TRS Medical Board and Medical Review Panel for the purpose of determining your eligibility for disability benefits.

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AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

TEACHERS' RETIREMENT SYSTEM
OF THE CITY OF NEW YORK (TRS)
55 Water Street, New York, NY 10041
www.trsnyc.org • 1 (888) 8-NYC-TRS

PART A: PERSONAL INFORMATION Please provide the information below.

First Name | MI | Last Name | Social Security Number (last 4 digits only) XXX—XX—☐☐☐☐

Permanent Home Address | Apt. No. | TRS Membership Number

City | State | Zip Code | Primary Phone Number (Check one: ☐Home ☐Work ☐Mobile)

Email Address | Alternate Phone Number (Check one: ☐Home ☐Work ☐Mobile)

☐ Check here if you entered new contact information above. TRS will then update our records based on what you entered.

Please keep your contact information up to date. You can visit our website to update your contact information anytime, or file a "Member's Change of Address Form" (code DM13) with TRS.

PART B: Please write your initials in the space provided to confirm your understanding of each statement.

_____ *I understand that TRS may re-direct the information described on this form on proper request if TRS is not required by applicable law to protect the privacy of this information and such information is no longer protected by federal health information privacy regulations.*

_____ *I understand that my medical records may contain information related to alcohol or drug abuse, genetic testing, psychiatric care, and/or confidential HIV/AIDS-related information.*

_____ *I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization unless permitted to do so under federal or state law. I also understand that I have the right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1 (888) 392-3644 or the New York City Commission on Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.*

_____ *I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above and hereby authorize any hospital, medical group, or other organization to disclose all my medical information to the Teachers' Retirement System of the City of New York (TRS).*

Member's Signature _____ Date (MM/DD/YYYY) _____

REPORT OF APPLICANT'S PHYSICIAN

TEACHERS' RETIREMENT SYSTEM
OF THE CITY OF NEW YORK (TRS)
55 Water Street, New York, NY 10041
www.trsnyc.org • 1 (888) 8-NYC-TRS

Please Print

Authorization to be completed and signed by applicant.

Dear Doctor _____:

You are hereby authorized by me to fill out this form and forward it to the Medical Board of the Teachers' Retirement System of the City of New York (TRS), 55 Water Street, New York, NY 10041.

Applicant's Name | TRS Membership Number

Signature: _____ Date (MM/DD/YYYY): _____

To be completed and signed by applicant's physician.

Report of disability in the case of _____

Title: _____ Work location: _____

*I certify that the above applicant has been under my professional care since:*_____
Month Day Year

The subjective and objective symptoms of which the applicant complains are as follows: _____

_____

_____

Diagnosis: _____

_____

_____

Treatment: _____

_____

_____

Prognosis: _____

_____

_____

In my opinion, and by reason of the above described condition, _____ *is physically or mentally incapacitated for the performance of duty; therefore, his/her disability retirement application should be approved.*

Signed: _____, M.D. Date (MM/DD/YYYY): _____

(STATEMENT TO BE RETURNED TO TRS)

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