LUMP-SUM DISABILITY BENEFIT APPLICATION

FOR MEMBERS WHO DO NOT MEET THE SERVICE REQUIREMENTS FOR ORDINARY DISABILITY RETIREMENT

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

INSTRUCTIONS

PLEASE READ CAREFULLY

- **In general, in-service members of TRS who have been diagnosed with a terminal illness (and have a life expectancy of one year or less), or who have been diagnosed with a medical condition of a long, continued, and indefinite duration requiring extraordinary care and treatment (regardless of life expectancy), may be eligible to receive a lump-sum disability benefit in accordance with Chapter 616 of the Laws of 1998, as amended by Chapter 409 of the Laws of 1999. Eligible members would receive a benefit equaling the amount payable (as a death benefit) had they died on the last day of active service. This benefit would be in lieu of any TRS disability benefit to which they may otherwise be entitled, and no benefits would be payable to beneficiaries.**
- **To be eligible for the lump-sum disability benefit, you must be in active service with, or on an official leave of absence from, the New York City Department of Education (DOE), the City University of New York (CUNY), or a participating Charter School, or be a transferred contributor to TRS.**
- ***Important Note: If you meet the service requirement for ordinary disability retirement (10 years of Total Service Credit for Tier I, II, IV, and VI members, and 5 years for Tier III), please do not file this form. Instead, you should file an ordinary disability retirement application for your tier, together with a "Lump-Sum Disability Benefit Request Form" (code DI19).***
- **Members who do not meet the service requirement for ordinary disability retirement must file this application to apply for the lump-sum disability benefit. You must complete all relevant sections of this application; you must also complete and file the attached Applicant's Personal Report of Disability. A completed "Report of Applicant's Physician" (code DI32) and an "Authorization for Release of Health-Related Information" (code DI47) must also be submitted to TRS before your application for the lump-sum disability benefit can be considered.**
- **If you are a Tier III, IV, or VI member, you must file this application within three months of your last date on payroll. If you were on an unpaid leave of absence for medical reasons, you must file your application no later than 12 months after receiving a termination notice.**
- **If you are approved for the lump-sum disability benefit, you would receive one lump-sum payment approximately 6-10 weeks following the date your application is approved by TRS' Medical Board.**
- **The effective date of the lump-sum disability benefit is different for each tier.**
  - **If you are a Tier I or Tier II member, the effective date of your lump-sum disability benefit would be the date of your medical examination, or another date you select that is within 30 days after the date of the Medical Board's approval.**
  - **If you are a Tier III member, the effective date of your lump-sum disability benefit would be the date your primary Social Security benefits begin, unless otherwise provided by law.**

CONTINUED ON PAGE 2

- **If you are a Tier IV or Tier VI member, the effective date of your lump-sum disability benefit would generally be the date you filed your application with TRS, provided you were not on payroll on that date. (If you were on payroll when you filed your application, your effective date would be the day following your last day on payroll.) If your application is approved, you will have the opportunity to choose a different date; that date must be within 30 days of the date the Medical Board approves your application.**

- **Please make a copy of this application for your records.**
- **The filing of this application is irrevocable.**
- **For more information on the lump-sum disability benefit, please consult the *Lump-Sum Disability Benefit* brochure. For your convenience, TRS forms and publications are available on our website.**

You must complete all parts of the application.

In Part A: All information must be provided.

In Part B: You must indicate whether you are a participant in TRS' Tax-Deferred Annuity (TDA) Program. When you separate from service, you may no longer make contributions to the TDA Program. Therefore, you must make a decision regarding the distribution of the funds in your TDA Program account. You may do one of the following:

- Withdraw all of your TDA funds by filing a "TDA Withdrawal Application" (code TD32) (and a "TDA Direct Rollover Election Form" (code TD22), if applicable);
- Receive your TDA funds as a monthly annuity by filing a "TDA Annuitization Election Form" (code TD6);
- Defer distribution of your TDA funds to a later date and leave them invested with TRS by filing a "TDA Deferral Status Election Form (For Retiring Members)" (code TD30); or
- Withdraw part of your TDA funds and either annuitize or defer receipt of the balance.

You must file the appropriate form(s), based on your election, in conjunction with this application.

In Part C: You must select (or agree to) the effective date of your lump-sum disability benefit.

In Part D: You must sign and date this statement in the presence of a notary public, who must then complete Part E.

In Part E: You must have this application notarized.

CONTINUED ON PAGE 3

LUMP-SUM DISABILITY BENEFIT APPLICATION

FOR MEMBERS WHO DO NOT MEET THE SERVICE REQUIREMENTS FOR ORDINARY DISABILITY RETIREMENT

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 read the instructions on pages 1 and 2 before completing this application.)

PART A: Please provide the information below.

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

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 check ONE of the following boxes, and write your initials in the space provided next to your choice.

____ ☐ *I am not a participant in the TDA Program.*

____ ☐ *I am filing a "TDA Withdrawal Application" (code TD32) to withdraw my TDA balance. If I want to reinvest these funds in an eligible successor program, I have also attached a "TDA Direct Rollover Election Form" (code TD22).*

____ ☐ *I am filing a "TDA Annuitization Election Form" (code TD6) to receive my TDA funds as a monthly annuity.*

____ ☐ *I am filing a "TDA Deferral Status Election Form (For Retiring Members)" (code TD30) to defer distribution of my TDA funds to a later date.*

____ ☐ *I am making a partial withdrawal of my TDA funds by filing a "TDA Withdrawal Application" (code TD32) and annuitizing the rest by filing a "TDA Annuitization Election Form" (code TD6).*

____ ☐ *I am making a partial withdrawal of my TDA funds by filing a "TDA Withdrawal Application" (code TD32) and deferring distribution of the rest by filing a "TDA Deferral Status Election Form (For Retiring Members)" (code TD30).*

PART C: Please check ONE of the following boxes, and write your initials in the space provided next to your choice.

I am a Tier I or II member, and I would like the effective date of my lump-sum disability benefit to be:

____ ☐ *the date of the TRS Medical Board's approval of my request for the lump-sum disability benefit.*

____ ☐ *a date* (to be selected later) *within 30 days after the Medical Board's approval of my request for the lump-sum disability benefit.*

I am a Tier III member, and I understand that the effective date of my lump-sum disability benefit will be:

____ ☐ *the date my primary Social Security benefits begin, unless otherwise provided by law.*

I am a Tier IV or Tier VI member, and I would like the effective date of my lump-sum disability benefit to be:

____ ☐ *the date I filed my disability application with TRS.*

____ ☐ *a date* (to be selected later) *within 30 days of the Medical Board's approval of my request for the lump-sum disability benefit.*

CONTINUED FROM PAGE 3

PART D: Please read the following statement and sign and date below in the presence of a notary.

I hereby affirm that I have read the accompanying instructions and have completed the appropriate portions of this application.

Pursuant to Chapter 616 of the Laws of 1998, as amended by Chapter 409 of the Laws of 1999, I hereby apply for the lump-sum disability benefit equal to the death benefit that would have been payable under TRS' Qualified Pension Plan (QPP) had I died on my last day of active service. I recognize that I may be eligible for this lump-sum disability benefit because I have been diagnosed with a terminal illness resulting in a life expectancy of one year or less, or have been diagnosed with a medical condition of a long, continued, and indefinite duration requiring extraordinary care and treatment (regardless of life expectancy). I certify that I am of "sound mind" when submitting this application.

I acknowledge that the benefit provided herein would be in lieu of any TRS disability benefit to which I may otherwise be entitled. I understand that, if approval is granted for my lump-sum disability benefit, I would receive one lump-sum payment, and no benefits would be payable to any beneficiaries. Should my death occur prior to my receipt of payment, I acknowledge that the benefit would be payable to my estate. I acknowledge that the filing of this application is irrevocable and shall be binding on my heirs. I acknowledge that, if I am approved for the lump-sum disability benefit, the effective date of my benefit would be governed by the rules outlined in the instructions to this application.

I further acknowledge that, if approval is granted for my lump-sum disability benefit and if I am restored to active service and again become an in-service member of TRS, no death benefit shall be payable in the event of my subsequent death. In addition, unless I render five years of Total Service Credit following such restoration, any retirement benefit to which I may thereafter become entitled to receive shall be reduced by the actuarial value of the lump-sum disability benefit paid to me in accordance with this election, and by the actuarial value of any applicable post-retirement death benefit.

I am aware that TRS' Medical Board may decide that I do not qualify for the lump-sum disability benefit. I also understand that, if my application for the lump-sum disability benefit is denied, my only option to appeal the decision is to supply new evidence for my case.

I affirm that, to the best of my knowledge, all information I have provided above is true and correct.

MEMBER'S SIGNATURE _____ DATE (MM/DD/YYYY) _____

PART E: 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 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

Address

City State Zip Code

TRS Membership Number

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

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

To TRS Medical Board
Teachers' Retirement System
of the City of New York
55 Water Street, New York, NY 10041

I believe I am incapacitated for further employment in my present position because _____

_____

_____

_____

_____

_____

_____

My physician, Dr. _____ ,
(Give Name in Full)

of _____, *advises me that*
(Give Address)

_____

_____

_____

_____

_____

MEMBER'S SIGNATURE _____ DATE (MM/DD/YYYY) _____

This page intentionally left blank.

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)

This page intentionally left blank.

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.

CONTINUED ON PAGE 2

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) X X X – X X – ☐ ☐ ☐ ☐

Permanent Home Address | Apt. No.

TRS Membership/Retirement 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 1 (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) _____