MUNICIPAL EMPLOYEES' RETIREMENT SYSTEM OF LOUISIANA (MERS)

DISABILITY APPLICATION CHECKLIST

PLEASE INCLUDE THE FOLLOWING WITH YOUR RETIREMENT APPLICATION. APPLICATIONS RECEIVED WITHOUT THE PROPER PAPERWORK WILL DELAY PROCESSING.

- ☐ Disability Application
- ☐ Salary Evaluation Form
- ☐ Direct Deposit Form - Mandatory
- ☐ Copy of Member's Birth Certificate and Social Security Card
- ☐ Copy of Beneficiary's Birth Certificate and Social Security Card (Required if Option other than Maximum Chosen)
- ☐ Copy of Certificate of Elected Service (Required for Elected Officials Only)
- ☐ Spousal Consent Form (Required only if Maximum chosen and Legally Married)
- ☐ Have final earnings and contributions been reported? Yes No (circle one)
- ☐ Certified Copy of Spouse's Death Certificate (Required if widowed)
- ☐ Copy of Divorce Judgment (Required if divorced)
- ☐ Disability Report by Immediate Supervisor
- ☐ Notification of Income from Other Sources
- ☐ Member Statement of Disabling Condition
- ☐ Copies of All Medical Records Pertaining to Disability
- ☐ A letter from your physician stating in their opinion you are disabled
- ☐ Authorization to Request Income Information

MUNICIPAL EMPLOYEES' RETIREMENT SYSTEM of LOUISIANA (**MERS**)
7937 Office Park Boulevard, Baton Rouge, Louisiana 70809
Phone: (800) 820-1137 or (225) 925-4810 – Fax: (225) 925-4816

APPLICATION FOR DISABILITY

Name: _____ Social Security # _____
Attach copy of card

Address: _____ Date of Birth: _____

_____ Employer: _____

Phone Number: _____ Marital Status – Circle One
Area Code + Number Never Married Legally Married Divorced Widowed

In accordance with the provisions of MERS, application is hereby made for Disability Retirement.

A. Selection is hereby made of the retirement benefit payment plan checked below:

(a) Maximum Allowance Plan ☐

(b) Option Plan Number _____ (Choice must be written in blank - Option No. 2, 3, 4.2, or 4.3)

(Please see page 2 for explanation of benefit options)

B. Are you now receiving Workers' Compensation or other disability benefits for this disabling condition?

☐ Yes ☐ No

If yes, you must complete "Notification of Income from Other Sources" and submit it with this application.

C. Have you ever received Workers' Compensation or other disability benefits for this disabling condition?

☐ Yes ☐ No

If yes, give the dates you received Workers' Compensation: _____

D. Do you receive income from any sources other than the job for which this disability claim is made, Social Security Administration, Veteran's Administration, or outside employment? ☐ Yes ☐ No

I hereby designate my beneficiary to receive eligible survivor benefits should I predecease him/her.

Name of beneficiary: _____ Date of Birth _____

Address: _____ Relationship _____

_____ Social Security # _____
Attach copy of card

_____
Witness (cannot be named beneficiary)

I, the undersigned, certify that I have had the above option chosen explained to me to my satisfaction.

_____ _____ _____
Witness (cannot be named beneficiary) Applicant's Signature Date

Member Name: _____ Social Security # _____

EMPLOYER'S CERTIFICATION

Has this member ever received Workers' Compensation (WC) or employer paid disability benefits? Yes No

The last day of service for which applicant will be paid is ____/____/_____

Date on which service of applicant will terminate is ____/____/_____

I have reviewed and certified correct to the best of my knowledge and belief:

Date: _____ Municipality: _____

Signature: _____ Title: _____
Clerk or Designated Authority

EXPLANATION OF BENEFIT PAYMENT PLANS

MAXIMUM ALLOWANCE PLAN – is the result of the retirement formula. The Maximum Plan pays the largest monthly benefit allowable to the retiree, but makes no provision for payments to a beneficiary. Under this plan, all benefits cease upon the death of the retiree, unless benefits paid to the member prior to death are less than the contributions made by the member prior to retirement.

OPTION NO. 2 – The member receives a reduced retirement allowance payable throughout life, with the provisions that the member designates a beneficiary at the time of retirement. If the beneficiary survives the member, the same benefit payment as the member received will continue to the beneficiary throughout the life of the beneficiary. The beneficiary may not be changed and, if the designated beneficiary does not survive the member, all retirement benefit payments cease upon the death of the member.

OPTION NO. 3 - The member receives a reduced retirement allowance payable throughout life, with the provisions that the member designates a beneficiary at the time of retirement. If the beneficiary survives the member, one-half of the member's retirement benefit will continue throughout the life of the beneficiary. The beneficiary may not be changed and, if the designated beneficiary does not survive the member, all retirement benefit payments cease upon the death of the member.

OPTION NO. 4 - The member receives a reduced retirement allowance payable throughout life, with the provisions that some other benefit or benefits shall be either paid to the member, or to such person or persons designated by the member, provided such other benefits, together with the reduced retirement allowance, shall not exceed the actuarial equivalent of the regular retirement allowance. NOTE: If the member selects this Option, the proposed retirement plan will be outlined in a letter attached to this application.

OPTION NO. 4.2 - The member receives a reduced retirement allowance payable throughout life, with the provisions that the member designates a beneficiary at the time of retirement. If the beneficiary survives the member, the same benefit payment as the member received will continue to the beneficiary throughout the life of the beneficiary. If the designated beneficiary dies before the retiree, the benefit paid to the retiree after the beneficiary's death will increase to what the retiree's Maximum benefit would have been.

OPTION NO. 4.3 - The member receives a reduced retirement allowance payable throughout life, with the provisions that the member designates a beneficiary at the time of retirement. If the beneficiary survives the member, one-half of the member's retirement benefit payment will continue throughout the life of the beneficiary. If the designated beneficiary dies before the retiree, the benefit paid to the retiree after the beneficiary's death will increase to what the retiree's Maximum benefit would have been.

IMPORTANT

If a retired member dies, without having received in retirement benefits an amount equal to his accumulated contributions standing to his credit at the date of his retirement, the balance remaining to his credit shall be paid to his designated beneficiary or, if none, his estate.

I understand that no changes in the Option elected by the member, other than to correct administrative error, shall be permitted after sixty days from date of receipt of retirement application by the board and, if an Optional plan of benefit payments is selected, the Option beneficiary may not be changed.

I have read and understand the above statement. Applicant's Signature: _____

MUNICIPAL EMPLOYEES' RETIREMENT SYSTEM OF LOUISIANA (MERS)
7937 Office Park Boulevard, Baton Rouge, Louisiana 70809
Phone: 225.925.4810, Toll-free: 1.800.820.1137, Fax: 225.925.4816, www.mersla.com

Disability Report by Supervisor

Please type or print in ink all entries except signatures.

This form must be completed by the employee's immediate supervisor. A copy of the employee's official job description must accompany this report when submitted to Municipal Employees' Retirement System (MERS). All responses to information requested should be complete and made to the best of your knowledge and ability. If additional space is required, you may use the reverse side or attach additional sheets. This form must be submitted along with "Application for Disability Retirement".

Section 1 - Member Information

Name: Last, First, MI, Suffix (Jr., III, etc.)

Title of Position	Social Security Number

Section 2 - Supervisor's Statements

1. Do you have any specific knowledge of the cause of the disabling condition? Yes ◯ No ◯ If yes, please describe.

2. In your opinion, when did the disabling condition begin to affect the applicant's performance or job duties?

_____ /_____/_____(month/day/year)

3. Specifically list the duties stated in the attached official job description that the applicant can no longer perform because of the disabling condition.

4. Specifically list the duties under your supervision that the applicant can still perform.

5. Did this applicant have any physical or mental handicap upon employment? Yes ◯ No ◯ If yes, briefly describe each.

Section 3 - Leave and Workers' Compensation

7. How many days of sick leave has this applicant taken since the onset of this disabling condition? _____

8. Was this an increase in the use of sick leave? Yes ◯ No ◯ If yes, please explain.

_____

9. Was this applicant advanced any extended sick leave days? Yes ◯ No ◯

10. Is this applicant currently receiving or has he or she ever received Worker's Compensation or any other disability benefits because of the disabling condition? Yes ◯ No ◯ If yes, please provide information below:

Name of Worker's Compensation Provider	Telephone Number
Address (Street/P. O. Box)	City, State, and Zip Code

Section 4 - Supervisor's Certification

I certify that the information contained in this form is true to the best of my knowledge.

Municipality Name	Supervisor's Name (Print in ink or type)	
Supervisor's Signature (Do not print or type)	Title	Date Signed (MM/DD/YYYY)

Municipal Employees' Retirement System
7937 Office Park Boulevard, Baton Rouge, Louisiana 70809
Phone: 225-925-4810, Toll-free: 1-800-820-1137, Fax: 225-925-4816

Notification of Income from Other Sources

Please type or print in ink all entries except signatures.

This form must be completed and submitted along with an Application for Disability Retirement if the applicant answered "yes" to questions in Section 1 of the application regarding workers' compensation and other sources of income.

Member Name:_____ Social Security Number: _____

Section 1 - Worker's Compensation

Note: Please have the Workers' Compensation insurance carrier provide MERS with a written statement verifying the information provided below:

Name of insurance carrier:	Address of insurance carrier:	
Phone number of insurance carrier:	Amount of monthly benefit:	Date first eligible to receive Workers' Compensation benefits:

Section 2: Income from other employment

Are you self-employed? Yes ☐ No ☐ **If yes:** Attach a separate sheet giving the name of the business, the type of business, an explanation of the type of work performed and the amount of annual income received from self-employment. MERS may contact you to request documents for verification of income reported.

Do you receive income from any source for which you receive a W-2 or 1099? Yes ◯ No ◯
If yes, please explain:

_____

Do you have a job other than the job for which this disability claim is made? Yes ◯ No ◯
If yes, complete the information below and attach a copy of two (2) recent pay stubs.
Do you plan to continue this employment? Yes ◯ No ◯

Employer's name:	Employer's address:	
Employer's phone number:	Monthly Salary:	Job Title:

Section 3 - Member and witnesses' signatures

I hereby certify that the information provided herein is true and correct. I agree to provide additional documents as may be required by MERS to verify the accuracy of this information. I understand that income I receive from sources not defined as "allowable income" by MERS could decrease the amount of my disability retirement benefit.

Signature of Member:	Date:
Print Name:	

Signature of Witness:

Print Name of Witness	Date:

Address of Witness:

Signature of Witness:

Print Name of Witness	Date:

Address of Witness:

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Member Statement of Disabling Condition

Please type or print in ink all entries except signatures

Describe, in detail, the nature of your disabling condition and how the condition affects current job performance. If additional space is needed, you may attach additional sheets. This statement must be submitted to the Municipal Employees' Retirement System (MERS) with the *Application for Disability Retirement*. Both pages of this form must be completed.

Section 1 - Member Information

Last Name	First Name	Middle Initial	Suffix (Jr., III, etc.)	Social Security Number

Address (Street/P. O. Box)	Primary Telephone Number
City, State, and Zip Code	Secondary Telephone Number
Title of Position	

Section 2 - Member Description of Condition

1. When did your disability begin? _____/_____/_____ (Enter as MM/DD/YYYY)
2. Were you treated for this condition prior to your employment with your current employer? Yes No

   If yes, date first treated: _____/_____/_____ (Enter as MM/DD/YYYY)

Information on treating physician:

Name of Physician	Primary Telephone Number
Address (Street/P. O. Box)	Area of Specialty
City, State, and Zip Code	

3. Describe the nature of your disabling condition:

4. Describe your job duties and how your disabling condition affects your ability to perform your job:

Member Statement of Disabling Condition - Continued

Member Name _____ Social Security Number _____

Section 2 - Member Description of Condition - Continued

5. Reports regarding my disability condition will be submitted by the following physicians who have examined me prior to submitting my Retirement Application to MERS (you may attach additional sheets if needed). One physician must be a specialist in the same area you are claiming disability. Copies of all available medical records, especially typed reports from lab tests, x-rays, MRIs, CT scans, etc., must also be submitted. DO NOT send the actual x-ray

Name of Physician	Primary Telephone Number
Address (Street/P. O. Box)	Area of Specialty
City, State, and Zip Code	
Name of Physician	Primary Telephone Number
Address (Street/P. O. Box)	Area of Specialty
City, State, and Zip Code	
Name of Physician	Primary Telephone Number
Address (Street/P. O. Box)	Area of Specialty
City, State, and Zip Code	
Name of Physician	Primary Telephone Number
Address (Street/P. O. Box)	Area of Specialty
City, State, and Zip Code	
Name of Physician	Primary Telephone Number
Address (Street/P. O. Box)	Area of Specialty
City, State, and Zip Code	

6. Mark the major area of specialty of the physician you consult for your disability. This will determine which LA State Medical Board physician will review your medical records. Mark only one box.

- ○ Internal Medicine (Gastroenterology, Nephrology, Pulmonary, Urology)
- ○ Neurology
- ○ Orthopedics (Rheumatology)
- ○ Cardiology
- ○ Oncology
- ○ Psychiatry
- ○ Other (Specify): _____

I understand that my application will not be submitted to the LA State Medical Board until all required information, including copies of all medical records pertaining to my disabling condition, is received from all physicians listed on this form.

Signature of Member (Do not print or type)	Date Signed (MM/DD/YYYY)

Municipal Employees' Retirement System (MERS)

Authorization to Request Information

I, _____, social security number (last 4 digits only) _____ understand that if approved for Disability retirement benefits, by way of this release, I give my permission and authorization to the Municipal Employees' Retirement System (MERS) to request information related to documentations or forms regarding earned income and/or benefit(s) I may be receiving now or in the future from the following sources: Internal Revenue Service, Department of Labor and/or the Social Security Administration.

_____ _____

Signature Date