

REEVALUATION APPLICATION FOR DISABILITY RETIREMENT BENEFITS FORM

Instructions: Please print or type in dark ink. The original of this form must be completed in its ENTIRETY and returned to PERA for processing.

Section I: General Information

Information regarding your disability application will not be released by PERA without your prior written consent

Please type or print so that others can read this information. Attach additional sheet(s) if necessary.

Name _____ SSN

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Address _____

City _____ State _____ Zip _____

Birth Date _____ Daytime Phone No _____

Height _____ Weight _____

Name of Spouse _____ Birth Date _____

I am submitting an application for permanent disability retirement because I believe I am totally and permanently Disabled. The nature of my _____ illness _____ injury _____ condition is

Is your illness, injury or condition a result of your job? _____ Yes _____ No

If yes, explain how _____

The reason(s) I cannot work are _____

Section II: Employment Information

Current or Last Employer _____

Address _____

City _____ State _____ Zip _____

This page must be completed in its ENTIRETY and returned to PERA for processing

FMLA _____

(Attach copy of job description)

GED _____ post graduate _____ degree _____

(Attach an extra page if necessary.)

Name of Claimant: _____ Social Security Number: _____

This page must be completed in its ENTIRETY and returned to PERA for processing

<u>Name</u>	<u>Location and telephone</u>	<u>Injury/Illness</u>	<u>Date Seen</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Were you performing your regular duties at the time the disability occurred? _____

Do you consider this disability to have occurred as the natural and proximate result of causes arising solely and exclusively out of and in the course of your employment with an affiliated public employer? _____

If so, why? _____

Have you sustained injuries in previous accidents or have you suffered illness or condition of this nature on previous occasions? _____ If yes, give complete details on a separate page explaining how, when, and where the accident or illness occurred, the nature and extent of the injury or illness, and by whom you were employed at the time.

Are you now or have you ever received compensation from the Veteran's Administration for injuries or illness which occurred while in the military service? _____ If yes, give complete details on a separate page explaining how, when, and where the accident or illness occurred, and the nature and extent of the injury or illness.

_____ If yes, when did you apply? _____

Are you receiving monthly benefits? _____ If yes, what is the amount of your benefits? \$ _____

Lump sum settlement? _____ If yes, amount of settlement? \$ _____

Present status with Worker's Compensation? _____

Have you applied for federal social security benefits? _____ If yes, when did you apply? _____

Are you receiving monthly benefits? _____ If yes, what is the amount of your benefits? \$ _____

If you have applied but are not receiving benefits, what is the status of your application? _____

By signature hereon, I declare that all information given is true and correct to the best of my knowledge and belief.

Applicant Signature: _____ Date: _____