



# Introduction

## Member's Application for Disability Retirement

Form Last Revised: February, 2020

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### **Before you file an application for a disability retirement allowance, please note that you should:**

- Contact your retirement board. This is an important step in ensuring that you have all of the information that you need. The staff at your retirement board will help you understand the process and respond to your questions throughout the process.

### **Read the *Guide to Disability Retirement for Public Employees***

- [www.mass.gov/perac](http://www.mass.gov/perac)
- This guide will give you general information about the disability process. Your retirement board can furnish you with a copy of this guide.

### **Next Step**

- Be sure to complete the entire application, including the release forms, and attach all required documents before returning your application to your retirement board. If your application is incomplete, the application process will be delayed. Until all of the required information has been submitted, your retirement board cannot assign a date of application, which will be very important in determining your effective date of retirement and retirement allowance date.
- Your retirement board can prepare an estimate of your retirement allowance for planning purposes at any time, but an official retirement allowance cannot be calculated until your application has been approved. If your application is approved, you may need to submit additional documents, including, if applicable, your marriage certificate, your spouse's birth certificate, and your dependent children's birth certificates.
- Before you send your application and your documents to your retirement board, make a photocopy of them for your own records.

### **Your Retirement Board Will:**

- Request information from your employer, your personal physician, and the other physicians, hospitals, and insurance companies that you identified on your application.
- You may, if you wish, submit the Physician's Statement to your primary treating physician. If you choose to do so, let your retirement board know so that duplication of effort can be avoided.

### **Next Step**

- When all the information specified above has been received by your retirement board, the application package is considered complete and your retirement board will decide whether to ask the Public Employee Retirement Administration Commission (PERAC) to set up a three member regional medical panel to examine you.



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### Timeframes

- The regional medical panel should meet within 60 days of being appointed by PERAC to conduct its examination.
- You will be given a 14 day notice of the scheduled examination(s).
- The regional medical panel will report their findings and recommendations to PERAC within 60 days after completing their examination(s).
- Within 5 days of receipt of a properly completed medical panel report, PERAC will forward the report to your retirement board.
- Your retirement board has the option at this point of requesting further information or a clarification from the regional medical panel if they determine that it would be helpful.
- Within 30 days of receipt of the report, your retirement board will notify you of the panel's findings and provide you with a copy of all of the documents completed by the regional medical panel.
- If the regional medical panel precludes retirement for the disability you claimed, your retirement board could either deny your application or it could ask PERAC for a new regional medical panel if the board believes that circumstances warrant it.

*If PERAC declines to schedule a new examination, your board will deny your application.*

- If the regional medical panel findings permit retirement for the disability claimed, your retirement board shall determine whether or not to approve the application.
- A hearing may be held on any disability retirement application and shall be held upon your request.
- If a hearing is scheduled, your board must give you at least a 30 day notice of the time and place for the hearing and the issues involved.
- Your retirement board's decision about your eligibility for disability retirement must be made no later than 180 days after you file your completed application, unless PERAC grants an extension.
- If your application is approved by your retirement board, it will be transmitted to PERAC for final action. PERAC must act on your application within 30 days of its receipt.
- If your application is denied by your retirement board, your retirement board will advise you of your right to appeal the decision.

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**Retirement Board:** Please place your address, phone number, fax number and email address here.

**Name of Retirement Board:**

**Address:**

**City/Town:**

**Zip Code:**

**Telephone:**

**Fax:**

## Applicant's Information

**Applicant's Full Name** (First, Middle Initial, Last)

**Former or Maiden Name** (if different)

\*\*\*-\*\*-\*\*\*\*

**Street Address**

**Social Security # (last four)**

**City/Town**

**State**

**Zip Code**

**Phone #**

**Email**

**Date of Birth**

**Place of Birth**

**Sex**

☐ M

☐ F

**Are You a Veteran?**

☐ YES

☐ NO

**If you will be residing at an address other than the one above (for example, a summer or retirement address) within the next 12 months, please list your alternate address below.**

**Alternate Street Address**

**City/Town**

**State**

**Zip Code**

**Phone #**

**To:**

**From:**

**Dates in Residence at Alternate Address** (Fill in To/From Above)

I understand that I have the right to apply for Accidental Disability and/or Ordinary Disability Retirement benefits. If I believe my disability may be the result of a job-related incident or injury, I may apply for Accidental Disability benefits and must answer all of the questions on this application. I will be required to provide evidence that my disability occurred as a result of a personal injury sustained or a hazard undergone while in the performance of my duties at a definite place and time without serious and willful misconduct on my part.

If I apply for Accidental Disability Retirement and PERAC approves my application after considering the Retirement Board's findings, the Regional Medical Panel Report and other evidence, I will be granted an Accidental Disability.

If I apply for an Accidental Disability and PERAC approves an Ordinary Disability application for me based on the Retirement Board's findings, the Regional Medical Panel Report and other evidence, then I may be retired for Ordinary Disability.

**I apply to be retired on the basis of:**

(Fill in the blank below with **ONE** of the following: **ACCIDENTAL**, **ORDINARY**, or **EITHER** for Accidental or Ordinary Disability)

*I sign this application under the penalties of perjury. I affirm that the information presented in this application is correct, complete and accurately presented. I understand that giving false or incomplete information on this application may subject me to loss of my benefits as well as civil and criminal penalties.*

**Applicant's Signature:**

**Date:**

# Member's Application for Disability Retirement

Disability Type: Member: SSN: 

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## Statement of Applicant's Duties

In order to receive a disability retirement allowance, a member must be permanently and totally disabled from performing the essential duties of his/her position. Essential duties are those duties or functions of a job or position that must necessarily be performed by an employee to accomplish the principal object(s) of the job or position. In accordance with PERAC's regulations, 840 CMR 10.07, your employer is required to identify the essential duties of your position.

1. Please state the medical condition(s) for which you are filing this application for disability retirement.

2. What is your current position and job title?

3. Is this a temporary or accommodated position?

4. Please describe the duties that you are required to perform in your current position.

5. How frequently are you required to perform these duties?

6. Please describe the duties that you are unable to perform as a result of your disability.

7. When did you cease to be able to perform all of the essential duties of your current position?

# Member's Application for Disability Retirement

Disability Type:  Member:  SSN: \*\*\*-\*\*-\_\_\_\_\_

## Your Employment History

### Your Current Position (From which you plan to retire)

<input type="text"/>		<input type="text"/>	
<b>Title</b>		<b>Name of Department</b>	
<input type="text"/>		<input type="text"/>	
<b>Employer's Street Address</b>		<b>Name of Head of Department</b>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>City/Town</b>	<b>State</b>	<b>Zip Code</b>	<b>Employer's Email Address</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<b>From:</b> <input type="text"/> <b>To:</b> <input type="text"/>
<b>Phone #</b>	<b>Fax #</b>	<b>Dates Employed</b> (Fill in From/To above)	

### Your Previous Positions

Please list all previous employment, beginning with your most recent position. Include all prior public and private employment. Please note that, if any other Massachusetts agency or unit has ever employed you, you may be eligible to purchase creditable service for that public sector employment. Contact your retirement board for further information about making such a purchase. If you need additional space, please attach a separate sheet.

<input type="text"/>	<b>From:</b> <input type="text"/>	<b>To:</b> <input type="text"/>
<b>Employer's Name</b>	<b>Dates Employed</b> (Fill in From/To above)	
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Street Address</b>	<b>City/Town</b>	<b>State Zip Code</b>
<input type="text"/>	<b>From:</b> <input type="text"/>	<b>To:</b> <input type="text"/>
<b>Employer's Name</b>	<b>Dates Employed</b> (Fill in From/To above)	
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Street Address</b>	<b>City/Town</b>	<b>State Zip Code</b>
<input type="text"/>	<b>From:</b> <input type="text"/>	<b>To:</b> <input type="text"/>
<b>Employer's Name</b>	<b>Dates Employed</b> (Fill in From/To above)	
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Street Address</b>	<b>City/Town</b>	<b>State Zip Code</b>
<input type="text"/>	<b>From:</b> <input type="text"/>	<b>To:</b> <input type="text"/>
<b>Employer's Name</b>	<b>Dates Employed</b> (Fill in From/To above)	
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Street Address</b>	<b>City/Town</b>	<b>State Zip Code</b>
<input type="text"/>	<b>From:</b> <input type="text"/>	<b>To:</b> <input type="text"/>
<b>Employer's Name</b>	<b>Dates Employed</b> (Fill in From/To above)	
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Street Address</b>	<b>City/Town</b>	<b>State Zip Code</b>

# Member's Application for Disability Retirement

Disability Type: Member: SSN: 

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## Statement About Recent Physical Activities

1. For the period of the last year, please describe your physical activities, including:

- Medical rehabilitation activities
- Activities of daily living (for example, driving, cleaning, etc.)
- Sports or other strenuous activities
- Other employment since the onset of your disability

## G.L. c. 32, § 15

1. Have you been officially investigated for or charged with misappropriation of funds from your employer or convicted of any crime related to your office or position? YES ☐ NO ☐  
If YES, please provide documentation.

*If you are only applying for ordinary disability, you are not required to complete the next section for accidental disability and can skip to page 10.*

# Member's Application for Disability Retirement

Disability Type: Member: SSN: 

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## Reason for Accidental Disability

One of the conditions for receiving approval of an application for accidental disability retirement is that your retirement board must find that your disability is the natural and proximate result of either a personal injury you sustained (usually, one or several specific incidents), or a hazard undergone (generally, exposure to a harmful situation over a period of time).

Certain employees may be eligible to apply for an accidental disability benefit under one of three statutory Presumptions described in Massachusetts General Laws, Chapter 32, Sections 94, 94A and 94B. Please direct your questions about your Presumptions to your retirement board.

**Please identify the reason for your disability:** Personal Injury ☐ Hazard ☐ Presumption ☐

In describing the personal injury that you sustained or the hazard to which you were exposed, it is important to be as specific as possible.

### Medical Condition

1. Date(s):

2. Specific time(s) or if hazard, length of time exposed:

3. Location(s):

4. Description of Incident(s), Hazard, or if applicable, why you are applying under a Presumption:

5. Job duties you were performing at the time of the incident:

6. In your own words, what is the injury(s) sustained as a result of the described incident?

### Other Conditions

1. Please describe any other circumstances, events, or physical conditions that contributed or may have contributed to your disability.

# Member's Application for Disability Retirement

Disability Type: Member: SSN: 

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## Incident Reports

Please provide the following information **about each person or agency** with which you filed a report of the injury(ies) that you sustained or the hazard to which you were exposed.

Agency		Name (First, Last, Middle)	
Street Address		City	State Zip Code
Phone #	Fax #	Email	Date You Filed Report
Agency		Name (First, Last, Middle)	
Street Address		City	State Zip Code
Phone #	Fax #	Email	Date You Filed Report

(Attach additional sheets if necessary)

## Witness Data:

For each witness to the incident(s) or hazard(s) that you've described, please provide the following information.

Name (First, Last, Middle)	Phone #	Relationship to You	
Street Address	City	State	Zip Code
Name (First, Last, Middle)	Phone #	Relationship to You	
Street Address	City	State	Zip Code

(Attach additional sheets if necessary)

# Member's Application for Disability Retirement

Disability Type: Member: SSN: 

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## Other Actions Taken

As a result of the incident(s) or hazard(s) that you have described, have you filed a grievance pursuant to a collective bargaining agreement? If **"YES"**, please describe the status of your grievance.

☐ YES☐ NO

Did your employer take any administrative or disciplinary action as a result of the Incident(s) or Hazard(s) you have described? If **"YES"**, please describe the current status of your litigation.

☐ YES☐ NO

Is there now or has there been, any other litigation in any forum regarding the injury upon which this application is based? If **"YES"**, please describe current the status of your litigation.

☐ YES☐ NO

## Workers' Compensation

Have you applied for, or are you receiving, or have you received weekly Workers' Compensation benefits or a Workers' Compensation settlement related to your claimed disability? If **"YES"**, please describe the current status of your Workers' Compensation.

☐ YES☐ NO

## Section 111F Benefits

Have you received or are you receiving benefits, related to your claimed disability, pursuant to Massachusetts General Laws, Chapter 41, Section 111F? If **"YES"**, please describe the current status of your Section 111F Benefit.

☐ YES☐ NO

## Other Payments

Have you received any other payments, assault, injury, etc. as a result of the injury upon which this application is based? If **"YES"**, please describe the current status of these payments.

☐ YES☐ NO

# Member's Application for Disability Retirement

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Disability Type: Member: SSN: 

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## Medical Treatment - Treating Physician

Your retirement board will request a statement certifying your disability status from the physician who is treating you for your disability. Please provide the following information about the physician who has provided you with treatment in connection with your disability.

<input type="text"/>		<input type="text"/>	
Health Care Provider's Name		Hospital/Facility	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street Address	City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Phone #	Fax #	Email	
From: <input type="text"/>		To: <input type="text"/>	
Dates of Treatment (Fill in From/To above)			

# Member's Application for Disability Retirement

Disability Type:  Member:  SSN: \*\*\*-\*\*-\_\_\_\_\_

## Physicians, Hospitals and Medical Facilities

Please list all physicians, hospitals and medical facilities with which you have consulted for your claimed disability. In addition, please list any physicians, hospitals and medical facilities at which you have received any treatment for any other condition within the last five years.

**Begin with your Emergency Room/Facility treatment regarding the injury claimed as the basis of your disability, followed by the most recent hospital or medical facility from which you sought a consultation or treatment.**

If you need more space, you may attach additional sheets.

### Name of Emergency Room/Facility

Facility Street Address

City

State

Zip Code

Phone #

Fax #

Email

From:

To:

Reason for Visit

Dates of Treatment (Fill in From/To above)

### Name of Physician or Facility

Facility Street Address

City

State

Zip Code

Phone #

Fax #

Email

From:

To:

Reason for Visit

Dates of Treatment (Fill in From/To above)

### Name of Physician or Facility

Facility Street Address

City

State

Zip Code

Phone #

Fax #

Email

From:

To:

Reason for Visit

Dates of Treatment (Fill in From/To above)

### Name of Physician or Facility

Facility Street Address

City

State

Zip Code

Phone #

Fax #

Email

From:

To:

Reason for Visit

Dates of Treatment (Fill in From/To above)

# Member's Application for Disability Retirement

Disability Type:  Member:  SSN: \*\*\*-\*\*-\_\_\_\_\_

## Attorney Information

If you are represented by an attorney in this disability retirement application process, please provide the following information so that we may contact him or her as necessary.

<input type="text"/>		<input type="text"/>	
Name of Attorney		Name of Firm	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street Address	City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone #	Fax #	Email	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

## Insurance Coverage

If you have any insurance that covers the incident(s) or hazard(s) that you have described, please provide the following information about each policy.

<input type="text"/>		<input type="text"/>	
Name of Insurance Company		Policy # (if known)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Insurance Co. Street Address	City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone #	Fax #	Email	Type of Coverage
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>		<input type="text"/>	
Name of Insurance Company		Policy # (if known)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Insurance Co. Street Address	City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone #	Fax #	Email	Type of Coverage
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

# Member's Application for Disability Retirement

Disability Type: Member: SSN: 

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The following authorization and selection forms are attached to your application. Make sure that you complete each of these forms and return them to your retirement board along with the rest of your completed application:

- Your signed *Authorization for Release of Medical and Insurance Records*
- Your signed *Regional Medical Panel Selection Form*

If your application is approved, you may need to submit additional documents, including, if applicable:

- Your marriage certificate
- Your spouse's birth certificate
- Your dependent children's birth certificates
- Your birth certificate
- Your military form DD214, if applicable

# Member's Application for Disability Retirement

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**Disability Type:**  **Member:**  **SSN:** \*\*\*-\*\*-\_\_\_\_\_

## Authorization to Use or Disclose Protected Health Information

I hereby authorize:

(physician, hospital, insurance company, employer, other health/rehabilitation entity)

to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to Federal or State law protecting its confidentiality. Information released on this authorization, if redisclosed by the recipient, is no longer protected.

**Patient Name**

**Date of Birth**

**Street Address**

**City**

**State**

**Zip Code**

**Information To Be Disclosed To** (Please check one): ☐

**PERAC**, 5 Middlesex Avenue, Suite 345, Somerville, MA 02145

☐ **Retirement Board** (Enter address below)

**Board Name:**

**Address:**

**City/Town:**

**State:**

**Zip Code:**

Please check one below to authorize release of your complete medical record, or, use the lines below to stipulate any exceptions.

☐ Authorize Release of Complete Medical Record

☐ Authorize Release of Complete Medical Record with the following exceptions

Exceptions:

This form encompasses the following:

- Disability Retirement Application: (Massachusetts General Laws, Chapter 32, Sections 6, 7, 26, 94, 94A and 94B)
- Restoration to Service Evaluation (including rehabilitation): (Massachusetts General Laws, Chapter 32, Sections 8 and 26)
- Accidental Death Benefit: (Massachusetts General Laws, Chapter 32, Sections 9 and 100)

I understand I may revoke this authorization at any time by notifying the Retirement Board or PERAC in writing, unless action has already been taken in reliance upon this authorization, or during an appeal under the applicable law.

This authorization will expire upon final determination of my disability application and Comprehensive Medical Evaluation/Rehabilitation/Restoration to Service process.

**Signature of Patient or Legal Representative:**

**Date**

**Printed Name of Patient or Patient's Rep.:**

**Relationship to Patient/  
Authority to Act for Patient, if applicable:**

# Member's Application for Disability Retirement

Disability Type: Member: SSN: 

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## About the Authorization to Use or Disclose Protected Health Information

All entries must be completed for this authorization to be valid.

Please note, Retirement Boards are not covered entities under the Health Insurance Portability and Accountability Act (HIPAA), however all information is treated in a confidential manner consistent with Federal and State privacy laws.

## How This Information is To Be Used

Pursuant to Massachusetts General Laws, Chapter 32, Section 6, the Public Employee Retirement Administration Commission (PERAC) is responsible for appointing regional medical panels to evaluate members seeking Disability Retirement. During the application process the Retirement Board and PERAC may obtain, share, and disclose information as necessary to complete the Disability Retirement process.

Pursuant to Massachusetts General Laws, Chapter 32, Sections 8 and 26, PERAC is also responsible for conducting Comprehensive Medical Evaluations (CMEs), offering Rehabilitation, and scheduling Restoration to Service (RTS) examinations to determine if the member is able to perform the essential duties of his/her former position, with or without rehabilitation. During this process, the Retirement Board and PERAC may obtain, share, and disclose information as necessary to complete this evaluation process. The information used/shared/disclosed during the four phases of the Disability process may include information provided by physicians, hospitals, insurance companies, employer, and other health/rehabilitation entities.

Please note, this original authorization form may be copied and reissued for the purpose of gathering and sharing protected information necessary to the Disability Application, CME, Rehabilitation, and RTS examinations.

Disability Type: Member: SSN: 

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**Medical Panel Selection**

Unless your retirement board denies your application as a result of an initial fact-finding hearing, you must have a regional medical panel examination. PERAC appoints all regional medical panels. When your retirement board determines that your application for disability retirement is complete, the board (which meets at least once each month) may petition PERAC to appoint a three-member state-financed independent regional medical panel to examine you.

No physician who has already examined you or treated you, except as part of a prior regional medical panel, can be appointed to a panel to examine you.

PERAC will schedule the regional medical panel examination(s) and notify you at least 14 days in advance of the date(s), time(s), and location(s).

**Regional Medical Panel Selection Form****Three Separate Single Examinations or One Joint Examination**

- You have the right to request three separate single physician examinations when you file your disability application.
- If you do not request separate single examinations at application filing time a joint panel can be convened.
- You may request separate examinations at any time prior to a joint examination date, but PERAC will not ordinarily consider requests for separate examinations less than 48 hours prior to a scheduled joint examination.

**You must indicate whether you prefer one joint examination or three separate single examinations by checking one of the boxes below:**

☐

I want to be examined by a joint regional medical panel.

☐

I want to be scheduled for three separate single examinations.

By signing, I acknowledge that if I fail to appear at the scheduled medical appointment(s), I will be required to reimburse the Commonwealth for the cost of the examination, prior to the scheduling of a new examination.

Signature of Applicant: Date:

# Member's Application for Disability Retirement

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Disability Type:

Member:

SSN:

## Addendum Sheet to the Member's Application for Disability Retirement

Please use this sheet to provide further information in the event that you find the space provided on the form to be insufficient. Please identify the question(s), by Page Number and Question Number, for which you are providing further information.



# Introduction

## Physician's Statement Pertaining to a Member's Application for Disability Retirement

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### Who should prepare this form?

In accordance with 840 CMR 10.06(1)(b) (Code of Massachusetts Regulations), every member-applicant shall file a statement from a licensed medical doctor.

### Who will ask the physician to complete this form?

In the *Disability Retirement Application* that an applicant submits to his/her retirement board, the applicant will identify the name, address, and phone number of the physician who has provided the care for his/her disability. The retirement board will send a copy of the Physician's Statement to the physician and request that the form be completed and returned to the retirement board.

Some applicants may choose to submit the *Physician's Statement* directly to their physician. Applicants should be sure to include the name, address, and phone number of their retirement board on the statement, if they take this course of action.

In order to avoid duplication of effort, if an applicant does submit the *Physician's Statement* directly to his/her physician, the applicant should be sure to inform his/her retirement board.

### What is the process associated with this form?

A voluntary disability retirement application will not be considered complete until the completed *Physician's Statement* has been received by the applicant's retirement board. Delays in filing any of the required materials will impede timely processing of the application.

### Are there terms particular to the legal process of disability retirement that the physician should consider when completing the *Physician's Statement*?

Yes, please review the last two pages of the *Physician's Statement*. Definitions are included for: Accidental Disability, Ordinary Disability, Risk of Re-injury, Aggravation of a Pre-Existing Condition, and the Permanency Standard.

Presumptions: If the applicant is applying for disability retirement for a Heart, Lung or Cancer Presumption, please review the definitions on page 9 of this form regarding the Heart, Lung or Cancer Presumptions.

### Who should a physician contact if he or she has questions about this form?

If a physician needs further explanation about this form or the disability process in general, the physician should contact the applicant's retirement board.

# Physician's Statement Pertaining to a Member's Application for Disability Retirement

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## Please return this form to:

Name of Retirement Board:

Address:

City/Town:

Telephone:

Zip Code:

Fax:

## Applicant Information:

			***-**-_____
Applicant's Last Name	First Name	M.I.	Social Security # (last four)

Former or Maiden Name (If different from above):

Street Address:

City/Town:

Phone Number:

Email:

State:

Zip Code:

Fax Number:

Type of Claimed Disability (Please check one):

☐ Accidental

☐ Presumption

☐ Ordinary

☐ Either Accidental or Ordinary

Applicant Last Name: First Name: SSN: 

\*\*\*-\*\*-\_\_\_\_

**Note to Physician:**

As a physician who has been treating the above named applicant for his or her claimed disability, the retirement board will consider your analysis of the applicant's medical condition. Attention to this document will help you translate medical findings and opinions into language consistent with Massachusetts law, which in turn will help your patient with the process. All definitions are included on page 9.

**Introduction:**

- You are asked to answer yes or no to questions (1) and (2) if the applicant is filing for an ordinary disability;
- You are asked to answer yes or no to questions (1), (2), and (3A) if the applicant is filing for accidental disability **without** a Presumption; and
- You are asked to answer yes or no to questions (1), (2), and (3B) if the applicant is filing for accidental disability **under** a Presumption.

**Applications for Accidental Disability under the Heart, Lung or Cancer Presumption**

- The physician submitting this form for a member who is applying for accidental disability benefits under the Heart, Lung or Cancer Presumption should note that certain conditions are presumed to be job-related if suffered by persons holding certain public safety positions. The physician should be aware that a higher level of certainty (higher than what a doctor typically refers to, i.e., reasonable degree of medical certainty) will be required to overcome or rebut a Presumption. Overcoming a Presumption requires a uniquely predominate non-work related influence.
- The Presumptions are found in Massachusetts General Laws, Chapter 32, Sections 94, 94A, and 94B; they are the Heart, Lung, and Cancer Presumptions. Please review the definitions and attached guides to completing these Presumptions before completing this form.

**Manner of Submission**

- You may either complete the narrative section of this report by handwriting your responses, or submitting a narrative utilizing the items listed as your template. Your office notes and test results may be attached to further substantiate your conclusions.

**Physician's Statement**

Applicant Last Name:

First Name:

SSN:

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**Question #1 - Incapacity**

■ Applicant's Date(s) of injury(ies) or exposure(s):

■ What are the applicant's medical diagnoses?

■ How long have you been treating this applicant?

■ Please list key tests or imaging or other data confirming diagnoses:

■ Applicant's Job Title:

■ Were the job duties reviewed?

☐

YES

☐

NO

■ When was this applicant last able to perform his or her essential duties?

■ Are there any essential duties that cannot be performed by the applicant?

■ Are there any medical restrictions that prevent the applicant from performing the essential duties of their position?

**Question 1 - Incapacity:**Is the applicant mentally or physically **incapable** of performing the essential duties of his or her particular job?☐

YES

☐

NO

## Physician's Statement

Applicant Last Name:

First Name:

SSN:

\*\*\*-\*\*-

**Question #2 - Permanency** (Please refer to the attached Permanency Standard)

- Has the condition(s) changed over time?

☐

YES

☐

NO

- In the past 3 months? (If YES, please describe how below)

☐

YES

☐

NO

- In the past year? (If YES, please describe how below)

☐

YES

☐

NO

- Your assessment of anticipated natural course of the diagnoses

☐

Stable or plateau

☐

Likely to regress

☐

Likely to resolve

- Has Maximum Medical Improvement (MMI) been reached?

☐

YES

☐

NO

**Non-surgical therapeutic interventions and outcomes:**

Medications:

PT:

Chiropractic:

Other:

**Surgical interventions and outcomes:**

Type of Surgery:

Date (mm/dd/yyyy):

Outcome:

Type of Surgery:

Date (mm/dd/yyyy):

Outcome:

Type of Surgery:

Date (mm/dd/yyyy):

Outcome:

Type of Surgery:

Date (mm/dd/yyyy):

Outcome:

(Section continued, next page)

**Physician's Statement**

Applicant Last Name:

First Name:

SSN:

\*\*\*-\*\*-\_\_\_\_\_

**Question #2 - Permanency** (continued from previous page)**Pursuant to PERAC Regulation 840 CMR 10.04(1)(b) please answer the following questions:**

- Is the nature of the condition or injury such that it can be expected to improve over a reasonable period of time? Please explain:

☐ YES ☐ NO

- Is the nature of the condition or injury such that it could be expected to improve if the applicant were willing to undergo reasonable medical treatment or rehabilitation? Please Explain:

☐ YES ☐ NO**Question 2 - Permanency:**Is the condition for which the applicant seeks disability retirement likely to be *permanent*?☐ YES ☐ NO

Complete question 3A if the applicant is filing an application for accidental disability ***without a Presumption.***

**Question #3A - Causation (Without a Presumption)**

- Describe the event(s) or onset of condition(s) that in your opinion led to applicant's disability:

- What other life event/circumstance/condition in the applicant's medical history may have contributed to or resulted in the disability claimed?

- Upon weighing the medical evidence, is it more likely that the disability was caused by the job-related personal injury or hazard undergone, or the non-work related event or circumstance or condition?

**Question 3A - Causation Without Presumptions:**

Is said incapacity such as might be the natural and proximate result of the claimed personal injury sustained or hazard undergone while in the performance of the applicant's duties?

☐ YES ☐ NO

**Physician's Statement**

Applicant Last Name:

First Name:

SSN:

\*\*\*-\*\*-\_\_\_\_\_

Complete question 3B if the member is filing an application for accidental disability ***under the Heart, Lung or Cancer Presumption.***

**Question #3B - Causation (With a Presumption)**

A presumption can be rebutted only by documentation of a uniquely predominant influence that shows the disability is not job-related or caused by a non-service connected accident or hazard.

If there is no evidence of such influence then you must answer **YES**. If there is such influence, you must answer **NO** to the question below.

**Question 3B - Causation With Presumptions:**

- For this particular applicant, is there any evidence of a uniquely pre-dominant non-service connected influence on his/her mental or physical condition which cause his/her incapacity? ☐ YES ☐ NO
- For this particular applicant, is there any evidence of a non-service connected accident or hazard which caused his/her incapacity? ☐ YES ☐ NO

If you answer **YES** to either of these questions, please explain the uniquely predominant influence or non-service connected accident which brings you to this conclusion:

**Based upon your review of above:**

Is said incapacity such as might be the natural and proximate result of the personal injury sustained or hazard undergone on account of which retirement is claimed?

☐ YES☐ NO

**Physician's Statement**

Applicant Last Name:

First Name:

SSN:

\*\*\*-\*\*-

**Physician's Certification****Physician Information:**

Name:

Street Address:

City/Town:

State:

Zip Code:

Phone Number:

Fax Number:

I am certified to practice medicine in:

(List All States That Apply)

Medical License Number :

Date issued (mm/dd/yyyy):

License Issued By (State):

Medical Specialty:

**Physician Signature:**

I, the undersigned physician, understand that \_\_\_\_\_ has applied for disability retirement pursuant to the provisions of Massachusetts General Laws, Chapter 32.

I have knowledge of the pertinent facts of this patient's case as described.

I certify that I have read and understand the information contained in this statement, and subscribe, under the penalties of perjury, that the information I have supplied in this statement and in my medical reports (if applicable) is true, complete, and correct to the best of my knowledge.

M.D.

Signature

Date

**Definition of Terms:**

**Ordinary Disability** In an application for Ordinary Disability Retirement, an applicant does not assert that his or her disability is the result of a job-related incident or injury. For such applications, your response to Question 3 is not necessary. But please note that you may also respond to Question 3, if your determination is that consideration of causality is appropriate even though the applicant has not applied for accidental disability retirement.

**Accidental Disability** In an application for Accidental Disability Retirement, an applicant asserts that his or her disability is the result of a job-related incident or injury. For such applications, your responses to Questions 1, 2, and 3 are required.

**Aggravation of a Pre-Existing Condition** You may find that a previous condition or injury is related to the condition or injury that is the basis of the disability application. If the acceleration of a pre-existing condition or injury is as a result of an accident or hazard undergone, in performance of the applicant's duties, causation would be established. However, if the disability is due to the natural progression of the pre-existing condition or was not aggravated by the alleged injury sustained or hazard undergone, causation would not be established.

**Risk of Re-injury** The Contributory Retirement Appeal Board (CRAB) has found, "...even if a member is physically capable of performing all of the essential duties of his or her position, he or she may be disqualified if a return to work would pose an unreasonable risk to serious harm to the member or third parties." *Filipek v. Bristol County Retirement Board*, CR-03-672 (CRAB 12/23/04). This risk of re-injury has to reasonably be expected to involve a substantial harm.

**Last Date of Service** The Contributory Retirement Appeal Board (CRAB) has found, an "employee who has left government service without established disability may not, after termination of government service, claim accidental disability retirement status on basis of subsequently matured disability" You are asked to address whether the member was disabled at the time he or she last performed their job duties. *Vest v. Contributory Retirement Appeals Board*, 41 Mass. App. Ct. 191, 194 (1996).

**Permanency Standard** A disability is permanent if it will continue for an indefinite period of time that is likely to never end even though recovery at some remote, unknown time is possible. If you are unable to determine when the applicant will no longer be disabled, you must consider the disability to be permanent. However, if the recovery is reasonably certain after a fairly definite time, the disability cannot be classified as permanent. It is imperative that the physician makes his/her determination based on the actual examination of the applicant and other available medical tests or medical records that have been provided.

**Presumptions** Certain conditions are presumed to be job-related if suffered by persons holding certain public safety positions. Additional information about these presumptions is available from the Public Employee Retirement Administration Commission. The presumptions are:

■ **Heart Presumption (Massachusetts General Law, Chapter 32, Section 94)**

A disability or death caused by heart disease or hypertension is presumed to be suffered in the line of duty for public safety positions, including certain fire fighters, police officers, corrections officers, and public safety employees at the international airport. The employee must have passed a physical examination on or after their date of hire which failed to reveal evidence of such a condition. The presumption can be rebutted by competent evidence which shows the disability was not job-related.

■ **Lung Presumption (Massachusetts General Law, Chapter 32, Section 94A)**

A disability or death caused by diseases of the lungs or respiratory tract is presumed to be suffered in the line of duty as a result of inhalation of noxious fumes or poisonous gas for certain fire fighters or public safety employees at the international airport. The employee must have passed a physical examination on or after their date of hire which failed to reveal evidence of such a condition. The presumption can be rebutted by competent evidence which shows the disability was not job-related.

■ **Cancer Presumption (Massachusetts General Law, Chapter 32, Section 94B)**

A disability or death caused by certain cancers is presumed to be suffered in the line of duty as a result of exposure to heat, radiant, or a known or suspected carcinogen for certain qualified fire fighters or public safety employees. The employee (or retiree) must have been employed in an eligible position on or after July 5, 1990, must have served in such a position for five years or more at the time such condition is or should have discovered, must have regularly responded to fires during some portion of his/her service, and must discover or should have discovered cancer within five years of the last date of his/her active service. The presumption can be rebutted by a preponderance of the evidence that shows that the disability was caused by non-service-related risk factors or accidents or hazards undergone.



# Introduction

## Choice of Option at Retirement

Pursuant to Massachusetts General Laws, Chapter 32, Sections 12(1) and 12(2)

Form Last Revised: February, 2020

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The *Choice of Option at Retirement* Form allows a member who has applied for retirement to select whether to receive their entire retirement allowance during their lifetime or to leave a lump sum or allowance for their survivor(s).

Keep in mind:

- You may only select one Option.
- Please consult with your retirement board to be certain that you understand the effect of selecting an Option. Your retirement board can provide you with a personalized estimate of each benefit.
- If you are married, the Spousal Acknowledgement on this form must be signed by your spouse.
- A disinterested witness should sign pages 6 and 7 of this form.

# Choice of Option at Retirement

Pursuant to Massachusetts General Laws, Chapter 32, Sections 12(1) and 12(2)

Form Last Revised: July, 2019

2

**Retirement Board:** Please enter your retirement board information here.

<b>Name of Retirement Board:</b>	<input type="text"/>		
<b>Address:</b>	<input type="text"/>		
<b>City/Town:</b>	<input type="text"/>	<b>Zip Code:</b>	<input type="text"/>
<b>Telephone:</b>	<input type="text"/>	<b>Fax:</b>	<input type="text"/>

## Member's Information:

<input type="text"/>	<input type="text"/>	<input type="text"/>	
<b>Member's Last Name</b>	<b>Member's First Name</b>	<b>Social Security # (last four)</b>	
<b>Street Address:</b>	<input type="text"/>		
<b>City/Town:</b>	<input type="text"/>	<b>State:</b>	<input type="text"/>
<b>Zip Code:</b>	<input type="text"/>		
<b>Email:</b>	<input type="text"/>		
<b>Phone:</b>	<input type="text"/>		

## Instructions

When you apply for retirement, you may select one of three retirement allowance payment Options (A, B or C). For the Option selection to be valid, this completed form must be filed with your retirement board:

- On or before the date the board receives your written application for retirement, or
  - On or before the date your allowance becomes effective, or
  - Not more than 15 days after the board receives a written application for your involuntary retirement from your department head.
1. You may change your Option selection before your retirement becomes effective by filing a new form.
  2. You may not change your Option selection once your retirement becomes effective.
  3. **If no Option selection is made, your allowance will be paid under Option (B).**
  4. If you are married, the spousal acknowledgement at the end of this form must be signed by your spouse.

# Choice of Option at Retirement

Member Last Name: First Name: 

SSN: \*\*\*-\*\*-\_\_\_\_

## 1. Explanation of Retirement Options

After reviewing **ALL** of the retirement options below, please select **ONE** option by checking the corresponding box in **Section 5** on page 6.

### Option (A) No Payment to Beneficiary

This Option provides for a full retirement allowance payable in monthly installments during your lifetime. All allowance payments will cease upon your death and no benefits will be provided for any survivors.

**Do not complete sections 3 & 4.**

### Option (B) Lump Sum Payment to Beneficiary

The payments under this Option are smaller than under Option (A). The annuity portion of your allowance is reduced to allow a lump sum benefit for your named beneficiary(ies). Upon your death, your named beneficiary(ies), or if there is no beneficiary living, the person or persons appearing in the judgment of the retirement board to be entitled thereto will be paid the unexpended balance of your annuity account. Please note that the contributions comprising the annuity account will be depleted within approximately twelve to fifteen years depending upon your age at retirement. The longer you live, the less will be paid to your beneficiary(ies) upon your death. If your account has been fully depleted, nothing will be paid to your named beneficiary(ies). You may designate and change at any time, one or more beneficiaries to receive in designated proportions, the lump sum Option (B) benefit. This Option takes effect upon your retirement and supercedes any prior beneficiary selections. **Do not complete sections 2 & 4.**

### Option (C) Payment of Allowance to Beneficiary

Election of Option (C) provides for a monthly retirement allowance during your lifetime that is less than you would receive under either Option (A) or Option (B). Upon your death your designated beneficiary will be paid a monthly allowance for the remainder of his or her lifetime. That allowance will be equal to two-thirds of the allowance that you were receiving at the time of your death. The monthly allowance you receive under Option (C) is based upon life expectancy factors for you and your designated beneficiary. Only your spouse, former spouse who has not remarried, mother, father, sister, brother or child may be designated as your Option (C) beneficiary. The younger your beneficiary, the smaller your retirement allowance will be. If, after you retire, your Option (C) beneficiary predeceases you, you will thereafter be paid the full retirement allowance you would have received had you elected Option (A) at the time your retirement allowance became effective. This conversion is commonly referred to as the Option (C) "pop-up". Please note that after the Option (C) "pop-up" takes place you may not name another Option (C) beneficiary or choose another Option.

**Do not complete sections 2 & 3.**

Choice of Option at Retirement

Member Last Name:

First Name:

SSN:

2. Option A Only

There is no beneficiary when Option A is selected. Of all three options, Option A provides the highest possible monthly allowance to a retiree. It does not provide for any continuing survivor benefits. Upon the death of the member who has selected Option A:

- All payments will stop.
- No future monthly payments will be made to anyone.
- No pay out of the remaining balance in the annuity account (if any) will be made.
- A pro-rata share of any amounts due at the death of the member (which will vary depending upon the date of the member's death) shall be payable to a recipient designated by the member.

I, , understand that in picking Option A only the amount of retirement allowance still owed to me at the time of my death will be payable to a recipient or recipients designated by me.

I hereby designate the following to receive the pro-rata share of my retirement allowance still due to me on the date of my death.

Pro-Rata Recipient or Recipients:

Pro-Rata Recipient or Recipients:					% of Benefit**
Full Name: (First, MI, Last):			SSN/EIN*:		
Relationship to You:		Phone:	Date of Birth:		
Address:					
Full Name: (First, MI, Last):			SSN/EIN*:		
Relationship to You:		Phone:	Date of Birth:		
Address:					
Full Name: (First, MI, Last):			SSN/EIN*:		
Relationship to You:		Phone:	Date of Birth:		
Address:					
Full Name: (First, MI, Last):			SSN/EIN*:		
Relationship to You:		Phone:	Date of Birth:		
Address:					
Full Name: (First, MI, Last):			SSN/EIN*:		
Relationship to You:		Phone:	Date of Birth:		
Address:					
Full Name: (First, MI, Last):			SSN/EIN*:		
Relationship to You:		Phone:	Date of Birth:		
Address:					
Full Name: (First, MI, Last):			SSN/EIN*:		
Relationship to You:		Phone:	Date of Birth:		
Address:					

\*Recipient's full Social Security Number (SSN) or Employer Identification Number (EIN), if an organization.  
\*\*Total must equal 100%; if no percentages are indicated, benefit will be allocated equally among recipients.

## Choice of Option at Retirement

Member Last Name:

First Name:

SSN:

\*\*\*-\*\*-\_\_\_\_\_

## 3. Option B Only — Beneficiaries

If you selected Option B, please fill in your beneficiary(ies) below:

## Beneficiary Information:

Beneficiary Information:			% of Benefit**
Full Name: (First, MI, Last):	SSN/EIN*:		
Relationship to You:	Phone:	Date of Birth:	
Address:			
Full Name: (First, MI, Last):	SSN/EIN*:		
Relationship to You:	Phone:	Date of Birth:	
Address:			
Full Name: (First, MI, Last):	SSN/EIN*:		
Relationship to You:	Phone:	Date of Birth:	
Address:			
Full Name: (First, MI, Last):	SSN/EIN*:		
Relationship to You:	Phone:	Date of Birth:	
Address:			
Full Name: (First, MI, Last):	SSN/EIN*:		
Relationship to You:	Phone:	Date of Birth:	
Address:			

\*Beneficiary's full Social Security Number (SSN) or Employer Identification Number (EIN), if an organization.

\*\*Total must equal 100%; if no percentages are indicated, benefit will be allocated equally among lump-sum beneficiaries.

%

## 4. Option C Only — Beneficiary

If you selected Option C, please fill in your beneficiary below. An Option C beneficiary may only be your spouse, former spouse who has not remarried, mother, father, sister, brother, or child.

Beneficiary's Name:

\*\*Relation to Member:

Date of Birth:

Social Security #:

Member's Signature

Date:

Member's Social Security # (last four):

\*\*\*-\*\*-\_\_\_\_\_

\*\*Please include birth certificate and marriage certificate, if applicable.

# Choice of Option at Retirement

Member Last Name:

First Name:

SSN:

\*\*\*-\*\*-\_\_\_\_

## 5. Option Selection and Signature

Please check the Option you have selected and sign your name at the bottom.

☐

### Option (A)

I choose to have my retirement allowance paid in accordance with the provisions of Massachusetts General Laws, Chapter 32, Section 12(2)(a) which provides the largest possible payment to me under the retirement law and that all payments thereunder cease at my death. No payment will be made to any beneficiary upon my death. If married, spouse must acknowledge this selection in Section 6.

☐

### Option (B)

I choose to have my retirement allowance paid in accordance with the provisions of Massachusetts General Laws, Chapter 32, Section 12(2)(b) which provides for a smaller retirement allowance for my life but provides that my designated beneficiary(ies) will receive any amounts remaining in my annuity account at my death. If married, spouse must acknowledge this selection in Section 6.

☐

### Option (C)

I choose to have my retirement allowance paid in accordance with the provisions of Massachusetts General Laws, Chapter 32, Section 12(2)(c) which provides an allowance which will be smaller than those under Option (A) or Option (B) but that upon my death two-thirds of this allowance will be paid to the named beneficiary for said beneficiary's life. If married, spouse must acknowledge this selection in Section 6.

**Member's Signature:** I have read and understand the provisions of Option ☐ selected above.

Print Name:

Signature:

Date:

Social Security # (last four):

\*\*\*-\*\*-\_\_\_\_

## 6. Witness Signature

**To Be Completed By Witness** (should be disinterested party):

**To the Retirement Board** - I have read this form with the member whose selection of an Option is made on this document and at his or her request have witnessed his or her signature thereto.

Witness' Name (Print):

Street Address:

City/Town:

State:

Zip Code:

Witness' Signature:

Date:

## Choice of Option at Retirement

Member Last Name:

First Name:

SSN:

\*\*\*-\*\*-\_\_\_\_\_

### 7. Spousal Acknowledgement

Unless there is a Domestic Relations Order in effect, if a member is married, the election of an option shall not be valid unless it is accompanied by the signature of the member's spouse.

- The member's spouse must indicate that he/she has reviewed the Option selected and understands it.
- It is up to the retirement board to explain the three options to the member and the spouse.
- If an option selection of a married member is not accompanied by a spouse's signature, the retirement board will take steps, outlined in the statute, to contact the member's spouse directly.

**IMPORTANT:** If you are the spouse of a member, please be certain you have read and understand the foregoing provision relating to your spouse's Option selection. If you do not understand any part of the Option selected by your spouse, please ask for an explanation from your spouse's retirement board. Your signature is not consent or approval, only an acknowledgement of the Option chosen by your spouse.

- Do not sign below unless you understand the Option selected by your spouse and the benefits to which you may or may not be entitled to at his/her death.

I am \_\_\_\_\_, the spouse of \_\_\_\_\_.

I understand my spouse has selected Option \_\_\_\_\_ as the method by which his/her retirement allowance will be paid. **This option may not be changed after retirement.**

#### Spouse's Signature

Spouse's Name (Print):

Spouse's Signature:

Date:

#### To Be Completed By Witness (should be disinterested party):

Witness' Name (Print):

Street Address:

City/Town:

State:

Zip Code:

Witness' Signature:

Date:



## AFFIDAVIT OF MEMBER AS TO MARITAL STATUS UPON RETIREMENT

I hereby affirm and attest as follows: [*Initial all that apply.*]

\_\_\_\_\_ I am not married.

\_\_\_\_\_ I am married to \_\_\_\_\_.  
(*Certificate of Marriage must be filed with MCRS.*)

\_\_\_\_\_ My spouse has witnessed the Option Selection Form and has knowledge and understanding of the retirement option I have selected.

\_\_\_\_\_ My spouse has not witnessed the Option Selection Form.  
(*Your retirement option will not be effective until thirty days after notice of your option selection is provided to your spouse by MCRS.*)

\_\_\_\_\_ I am divorced.

Please provide the following information for **all** divorces. Attach an additional sheet if necessary.

I was formerly married to \_\_\_\_\_  
and became divorced on \_\_\_\_\_. The Judgment of Divorce,  
Settlement Agreement and/or Domestic Relations Order (does \_\_\_\_\_) (does not \_\_\_\_\_)  
obligate MCRS to pay benefits to my former spouse or to children of this marriage.  
(*An attested copy of the Judgment of Divorce, Divorce Agreement and/or Domestic Relations Order, must be filed with MCRS prior to the effective date of your retirement.*)

I understand that misrepresentations regarding marital status and the existence of court ordered payments may result in criminal and civil liability.

***SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY***

\_\_\_\_\_  
MEMBER'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE

\_\_\_\_\_  
DATE



Commonwealth of Massachusetts  
**MIDDLESEX COUNTY RETIREMENT SYSTEM**  
25 LINNELL CIRCLE • P.O. BOX 160 • BILLERICA, MA 01865  
WWW.MIDDLESEXRETIREMENT.ORG

*Over 100 Years of Public Service*

CHAIRMAN  
THOMAS F. GIBSON, ESQ.

BRIAN P. CURTIN

JOSEPH W. KEARNS

JOHN BROWN

ROBERT W. HEALY

Chief Administrative Officer  
LISA MALONEY, ESQ.

**ACKNOWLEDGEMENT OF OFFSET OF WORKER'S COMPENSATION  
AND THIRD PARTY RECOVERY FROM DISABILITY RETIREMENT AND  
ACCIDENTAL DEATH BENEFITS**

**Workers' Compensation (Not applicable to police officers or fire fighters)**

I acknowledge that workers' compensation payments I receive as a result of the same injury or death from which I am seeking disability retirement or accidental death benefits will be offset from my disability retirement or accidental death benefits. I acknowledge that I have an obligation to diligently pursue workers' compensation benefits and that my failure to do so may result in a suspension of retirement benefits. I further acknowledge that the Middlesex County Retirement System may file a claim on my behalf.

**Third Party Recovery (Applicable to all disability retirement and accidental death applicants)**

I acknowledge that the recovery of lost wages from a third party other than my employer resulting from the same injury or death will be offset from my disability retirement or accidental death benefits. I acknowledge that the failure to pursue a third party claim where appropriate may result in a suspension of retirement benefits. I further acknowledge that the Middlesex County Retirement System may file a claim on my behalf.

**I AGREE** to cooperate with the Middlesex County Retirement System with reference to the above, and to notify the Middlesex County Retirement System of any changes in my workers' compensation status. I further agree to notify the Middlesex County Retirement System of the filing of any claim against a third party, and to notify the Middlesex County Retirement System **PRIOR** to settlement of a workers' compensation and/or a third party claim resulting from the same injury or death.

**I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS NOTICE.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Member's Signature



*Commonwealth of Massachusetts*  
**MIDDLESEX COUNTY RETIREMENT SYSTEM**  
25 LINNELL CIRCLE • P.O. BOX 160 • BILLERICA, MA 01865  
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*Over 100 Years of Public Service*

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JOSEPH W. KEARNS  
  
JOHN BROWN  
  
ROBERT W. HEALY  
  
**Chief Administrative Officer**  
LISA MALONEY, ESQ.

**EMPLOYEE'S AUTHORIZATION TO RELEASE  
WORKERS' COMPENSATION INFORMATION**  
**840 CMR 10.06(1)(g)(4)**

**Employee:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Insurer:** \_\_\_\_\_

**Claim No.:** \_\_\_\_\_

**Date(s) of Injury:** \_\_\_\_\_

I hereby consent, without restriction, to release to the Middlesex County Retirement System, all workers' compensation records pertaining to the above claim, including, but not limited to:

Records of all physicians or medical institutions; records of all physical examinations performed; accident reports, claim and investigation reports; Agreements for Compensation; Department of Industrial Accidents Orders, Decisions and approved Settlements.

I understand that this information may contain details of a highly personal or intimate nature, and that the information and records may be otherwise exempt from disclosure, except where authorized by law or regulation.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Signature



Commonwealth of Massachusetts  
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ROBERT W. HEALY  
  
**Chief Administrative Officer**  
LISA MALONEY, ESQ.

**ACKNOWLEDGEMENT OF RECEIPT OF DISABILITY BENEFITS**

TO: APPLICANTS FOR DISABILITY RETIREMENT BENEFITS  
APPLICANTS FOR ACCIDENTAL DEATH BENEFITS

I hereby acknowledge that I have applied for, am receiving, or have received the following disability benefits (check all that apply):

\_\_\_\_\_ Social Security Disability Insurance (SSDI)  
*Please provide copy of Social Security Benefit Verification Letter ("Social Security Award Letter")*

\_\_\_\_\_ Veterans Administration Disability Compensation (VA Benefits)  
*Please provide copy of Veterans Administration Benefit Summary Letter ("VA Award Letter")*

\_\_\_\_\_ Short Term/Long Term Disability Benefits (STD/LTD Benefits)  
*Please provide copy of award letter from disability benefit provider*

\_\_\_\_\_ I have not applied for nor have I received any of the above.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Member's Signature