IDENTIFICATION

In order to process your application, PERA will need proof of your age and identity. We will need the same types of documents for anyone you name as your survivor. **Please send photocopies of these documents as originals will not be returned.**

ANY ONE OF THESE DOCUMENTS IN YOUR CURRENT NAME WILL PROVE YOUR AGE AND IDENTITY:

- Passport or passcard
- Enhanced Driver's License
- State Real ID

AGE—IF YOU DO NOT HAVE ONE OF THE ABOVE DOCUMENTS: one of the following may be submitted for proof of age.

- Birth certificate
- Church record showing your birth date
- Hospital birth record
- Military record
- Marriage certificate showing your birth date
- Naturalization record (citizenship paper)
- Immigration record established upon arrival in the United States

IDENTITY—IF YOU HAVE CHANGED YOUR NAME: you must ALSO provide documentation for ALL name changes.

- Certificate of marriage
- Affidavit or other document issued by a court
- Church record of marriage, certified by custodian of such record
- Child's birth certificate showing your maiden name

If you furnish a document that is in a foreign language, someone who is familiar with the language (other than yourself) must prepare an affidavit of translation and sign it before a notary public. The affidavit must be sent to the PERA office with the appropriate document.

We reserve the right to see the originals or certified copies if necessary.

ADDITIONAL APPLICATION INFORMATION

MY PERA at mnpera.org provides benefit estimates and other information on your personal account with PERA. Once you are drawing a benefit you may make changes to your direct deposit and tax withholding online. Additional information on your retirement plan is also available on our website.

PRIVATE DATA AS REQUIRED BY MINN. STAT. § 353.29, SUBD. 4: PERA is asking for private data in order to process your request. You are not legally required to provide this information and may refuse to provide all or some of the information requested. However, PERA may not be able to process your request if you do not provide sufficient information. Unless you consent to further release of your private data, access to this information will be limited to the PERA staff who process your request. Your private data may also be released if required or authorized by state or federal law or by a court order.

IRS RESTRICTIONS: As a 401(a) tax qualified plan, the Public Employees Retirement Association must follow benefit requirements set by the Internal Revenue Service (IRS). Among these requirements is a limitation on the total amount of annual benefits under Section 415 of the IRC ($210,000 in 2015).

RETURN COMPLETED FORM TO:

Public Employees Retirement Association
60 Empire Drive, Suite 200, St. Paul, MN 55103-2088
1-800-652-9026 | 651-296-7460 | mnpera.org

DO NOT SUBMIT BY FAX OR EMAIL

PERA

APPLICATION FOR DISABILITY BENEFITS

POLICE & FIRE

POLICE & FIRE PLAN

Instructions: PLEASE PRINT. Original application must be completed in black or blue ink and signed by the PERA member (and spouse, if married) before a notary public. Alteration of the information provided on pages 1, 6, and 7 of this application will invalidate this form.

PART A — MEMBER INFORMATION

DISABILITY TYPE

☐ Duty Disability ☐ Regular Disability ☐ Total and Permanent Duty Disability ☐ Total and Permanent Regular Disability

(Refer to Disability Definitions in the Disability folder for explanations of these terms)

NAME—LAST, FIRST, MIDDLE INITIAL			PERA ID NUMBER
ADDRESS—STREET, CITY, STATE, AND ZIP CODE			BIRTH DATE—MM/DD/YYYY / /
CITY	STATE	ZIP	LAST FOUR OF SSN
PRIMARY PHONE NUMBER	ALTERNATE PHONE NUMBER		
PERSONAL EMAIL ADDRESS	MARITAL STATUS ☐ Married ☐ Unmarried (proceed to part C)		

PART B — SPOUSE INFORMATION

NAME—LAST, FIRST, MIDDLE INITIAL			BIRTH DATE—MM/DD/YYYY / /
ADDRESS—STREET, CITY, STATE, AND ZIP CODE			
CITY	STATE	ZIP	
PRIMARY PHONE NUMBER	ALTERNATE PHONE NUMBER	EMAIL ADDRESS	

PART C — DIRECT DEPOSIT

You may tape a voided check to this section. **If you choose to deposit into a savings account, you MUST contact your financial institution to verify the correct ACH routing number, as it may not be the same number displayed on your deposit slip.** DO NOT attach a deposit slip. If there is a joint account holder, please notify them of their obligation to repay any overpayment to this account in the event of your death if the overpayment is not repaid by the financial institution.

TYPE OF ACCOUNT ☐ Checking ☐ Savings	FINANCIAL INSTITUTION	INSTITUTION PHONE NUMBER
⑆000000186⑆ 000000529⑈ Routing Number Account Number	ROUTING NUMBER	ACCOUNT NUMBER

PART D – BENEFIT SELECTION

Any alteration of the information you provide on this page of the application (white out, cross-out, etc.) will invalidate this form. **Please refer to your benefit estimate** or visit mnpera.org for a full explanation of these benefit options. Your estimate will provide the dollar amount associated with each option.

PERA cannot issue a benefit payment until we have substantiated age and identity for you, and your named survivor should you choose a survivor benefit option below. See page 8 for a list of acceptable identification documents.

CHOOSE ONLY ONE OPTION BELOW TO INDICATE YOUR RETIREMENT BENEFIT SELECTION.

SINGLE-LIFE BENEFIT

☐ All benefits end upon your death with the exception of a Total and Permanent Duty Disability (Proceed to Part I)

OR

SURVIVOR BENEFIT OPTIONS

Instead of a single-life benefit, you may choose one of the four survivor options below. Please provide the requested information about your designated survivor, as well as their proof of age and identity.

If choosing a non-spouse survivor, age restrictions may apply when selecting the 75% or 100% options. For more information, see the Survivor Options Fact sheet at mnpera.org.

☐ **25% Survivor Option**

☐ **50% Survivor Option**

☐ **75% Survivor Option**

☐ **100% Survivor Option**

SURVIVOR'S INFORMATION

NAME–LAST, FIRST, MIDDLE INITIAL			
IS THIS YOUR SPOUSE? ☐ Yes ☐ No	SOCIAL SECURITY NUMBER - -	BIRTH DATE–MM/DD/YYYY / /	GENDER ☐ Male ☐ Female

PART E – NOTARIZED SIGNATURE OF PERA MEMBER (AND SPOUSE IF MARRIED)

Only the original application with signature and notary will be processed. Do not submit by fax or email.

FOR COMPLETION BY PERA MEMBER

I have read and understand the information on this application and understand that I am applying for a disability benefit and the benefit selection indicated above, and that this benefit is contingent on PERA approval of my disability status. I further understand that the option I have chosen above is irrevocable for the duration of my disability benefit.

_____

Signature of Member

FOR COMPLETION BY NOTARY

Subscribed and sworn to before me this

_____ Day of _____, Year _____

_____

Signature of Notary

Notary Public of _____ County.

My Commission Expires _____

(Seal Required)

FOR COMPLETION BY MEMBER'S SPOUSE

A married member's application will be delayed without a notarized signature of the spouse. The application will be delayed by 60 days or more while PERA notifies the spouse of the application and benefit selection. If the spouse's signature is not received, by operation of law the 50 percent survivor option will be paid if the member selected either the single life or 25 percent survivor option.

I hereby acknowledge the benefit selection made by my spouse.

_____

Signature of Member's Spouse

FOR COMPLETION BY NOTARY

Subscribed and sworn to before me this

_____ Day of _____, Year _____

_____

Signature of Notary

Notary Public of _____ County.

My Commission Expires _____

(Seal Required)

PART K – EMPLOYMENT INFORMATION

Are you currently working in a police, fire, paramedic, or correctional officer position?

☐ Yes (complete the current employment information below)

☐ No. I am on an employer-approved leave of absence as of _____
(Month, Day, Year)

☐ Leave with pay ☐ Leave without pay Name of employer that approved the leave: _____

☐ No. If you terminated employment, provide date of termination: _____
(Month, Day, Year)

Note: If you terminated more than 18 months ago, you are not eligible to apply.

Are you currently working in a non-police, non-firefighter, non-paramedic, or non-correctional position?

☐ Yes (complete current employment information below). ☐ No

Current Employment:

Employer 1: _____

Position: _____ Rate of pay _____

Dates of employment: _____

☐ Full-time ☐ Part-time ☐ Full Time Seasonal ☐ Other: _____

Employer 2: _____

Position: _____ Rate of pay _____

Dates of employment: _____

☐ Full-time ☐ Part-time ☐ Full Time Seasonal ☐ Other: _____

PART J — NOTICE, INFORMED CONSENT AND AUTHORIZATIONS

NOTICE TO MEMBER.

Your PERA ID number, social security number, address, birth date, marital status, designated survivor option information, spouse information, and medical information are classified as private data. PERA will not share your private data with any person or agency except pursuant to your Authorization, below, or an order from a court or Administrative Law Judge. If you do not provide the information requested by PERA or MMRO, the processing of your application for disability benefits may be impaired.

A photocopy or facsimile of this Informed Consent and Authorizations shall be as valid as the original.

INFORMED CONSENT AND HIPAA AUTHORIZATION.

RELEASE OF INFORMATION TO PERA AND MMRO

I give my informed consent and authorize the release of my employment, medical and health care data to the Public Employees Retirement Association (PERA), its disability case manager Managed Medical Review Organization (MMRO), and any independent medical examiners and consultants retained by PERA or MMRO, for the purpose of evaluating my application for PERA disability benefits and conducting related appeals, by:

_____ (initial) My current or former PERA-covered employer

_____ (initial) Heath care providers, medical facilities, and hospitals

_____ (initial) Rehabilitation consultants

_____ (initial) Independent medical examiners

The following information may be disclosed: all medical and health care records and relevant information from any source with respect to any physical or mental condition and/or treatment of me, including information regarding AIDS/HIV infection, communicable diseases, mental health, and alcohol or substance abuse. I understand that the information used or disclosed may be subject to re-disclosure by PERA and MMRO as necessary to evaluate my application for disability benefits and to conduct a fact finding conference, PERA Board of Trustees Hearing, or appeal, and would then no longer be protected by federal privacy regulations.

RELEASE OF INFORMATION BY PERA AND MMRO

_____ (initial) I authorize disclosure of my employment, medical and health care data by PERA and MMRO to my current or former PERA-covered employer, the Office of Administrative Hearings, the PERA Board of Trustees and the Minnesota appellate courts as necessary to obtain information relevant to my application for disability benefits, to evaluate my application for disability benefits, and to conduct a fact-finding conference, PERA Board of Trustees Hearing, or appeal authorized by Minn. Stat. §§ 356.96 and 299A.456. Any other disclosure of my employment, medical and health care data by PERA or MMRO is governed by the Minnesota Government Data Practices Act, Minn. Stat. ch. 13.

Revocation or failure to sign. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization. I understand that failing to sign this Authorization, or revoking this Authorization, may impede the processing of my application for disability benefits or result in the denial of my application.

Effective date and expiration. This authorization is effective on the date appearing next to my signature below and expires upon the final determination of my eligibility for PERA disability benefits and, if applicable, continued employer health insurance, including appeals authorized by Minn. Stat. §§ 356.96 and 299A.456.

Copy. I understand that I may request a copy of this authorization from PERA or MMRO.

Member signature: _____ Date: _____

PART F — FEDERAL INCOME TAX WITHHOLDING

CHOOSE ONLY ONE OPTION

1. No federal tax withholding.
2. Withhold federal tax based on selections below:

Marital Status: Single / Married / Married, but withhold at higher Single rate

Total exemptions claimed:_____

Optional: In addition to the amount generated by the current tax tables, I would like $_____ (in whole dollars) withheld.

Note: If you do not make a selection, and no previous selection has been made, federal law requires PERA to withhold federal tax from your benefit assuming a status of married with three exemptions. Your withholding selection will be in effect until you change it.

PART G — MINNESOTA INCOME TAX WITHHOLDING

CHOOSE ONLY ONE OPTION

1. No Minnesota state tax withholding.
2. Withhold Minnesota state tax based on selections below:

Marital Status: Single / Married / Married, but withhold at higher Single rate

Total exemptions claimed:_____

Optional: In addition to the amount generated by the current tax tables, I would like $_____ (in whole dollars) withheld.

If you do not make a selection, PERA will not withhold Minnesota state income taxes. Your withholding selection will be in effect until you change it.

PART H — ILLNESS/INJURY INFORMATION

Describe the illness/injury that caused your disability. Provide any additional information you feel is pertinent to support your claim."

HEALTH CARE PROVIDERS

List the health care providers you consulted regarding the injury/illness causing your disability.

You must also submit two separate PERA Medical Reports – at least one PERA Medical Report must be signed by a licensed medical doctor and at least one additional form signed by a medical doctor, psychologist, psychiatrist or chiropractor – as well as medical records supporting your application for disability benefits.

NAME OF HEALTH CARE PROVIDER AND CLINIC		PERIOD TREATED: FROM-TO
ADDRESS		
PHONE NUMBER	FAX	EMAIL

NAME OF HEALTH CARE PROVIDER AND CLINIC		PERIOD TREATED: FROM-TO
ADDRESS		
PHONE NUMBER	FAX	EMAIL

NAME OF HEALTH CARE PROVIDER AND CLINIC		PERIOD TREATED: FROM-TO
ADDRESS		
PHONE NUMBER	FAX	EMAIL

PART I – WORKERS COMPENSATION

Did the illness/injury causing your disability occur on the job?

☐ Yes ☐ No

If Yes, describe how your injury/illness occurred and what duties you were performing at the time of your injury/illness:

_____

_____

_____

_____

_____

When did your disabling illness/injury begin?: _____
(Month, Day, Year)

Job description:
If the date your disabling illness/injury began is more than two years ago, please provide a job description for the position held within the 90 days prior to filing this application. If the date of illness/injury is less than two years ago, please provide a copy of the job description of the position held at the onset of the illness/injury.

Was a First Report of Injury completed?

☐ Yes ☐ No

To claim a duty-related disability benefit, you must provide a copy of the First Report of Injury filed with your employer. If you do not provide a First Report of Injury, your application will be processed as a regular disability.

Did your health care provider give you or your employer a report on your ability to work?

☐ Yes (attach a copy of the report) ☐ No

Indicate your status with respect to workers' compensation. Attach a copy of the Stipulation and Award or provide the name and address of the Workers' Compensation Carrier. Mark (X) all applicable boxes below to identify your status.

☐ Did not apply ☐ Applying for benefits ☐ Receiving benefits ☐ Denied benefits ☐ Benefits discontinued

Workers' Compensation Carrier: _____

Workers' Compensation Carrier's Address: _____

Telephone Number: _____

PERA

REQUIRED EMPLOYER INFORMATION

POLICE & FIRE AND CORRECTIONAL PLANS

Instructions: PLEASE PRINT using blue or black ink. Complete this form and return it to PERA within 14 days.

Minn Stat. §353.656 and 353.031, subd. 4, require the employer of an applicant for disability benefits to provide information to PERA. Authorizations for release of information signed by the applicant on their disability application allow you to share relevant information, including protected health information, with PERA.

PART A – TO BE COMPLETED BY PERA

APPLICANT NAME–LAST, FIRST, MIDDLE INITIAL	PERA ID NUMBER

The applicant applied for the following disability benefit on: _____

Applicant indicated date of injury was: _____

Type of disability applied for:

☐ Duty Disability ☐ Regular Disability ☐ Total and Permanent Duty Disability ☐ Total and Permanent Regular Disability

PART B – FOR COMPLETION BY EMPLOYER

Verify the information in Part A. Complete Part B and C. Give the completed form to the employee or send it to our office. If the member changes their termination date after you submit this form, notify PERA immediately.

EMPLOYER	EMPLOYER CONTACT
EMPLOYER ADDRESS	
CONTACT PHONE NUMBER	CONTACT EMAIL

1. **Date of the onset of the illness/injury causing the Applicant's disability** _____ **(Month, Date, Year)**
2. **When did the Employer learn of the illness/injury?** _____ **(Month, Date, Year)**
3. **Did the illness/injury occur while the Applicant was performing a job duty?** ☐ Yes ☐ No

   If yes, describe the job duty: _____

   Was this job duty specific to: ☐ **Police or** ☐ **Fire or** ☐ **Correctional work?** ☐ Yes ☐ No

   If yes, explain your answer:

   _____

   _____

   Was this job duty inherently dangerous? ☐ Yes ☐ No

   Explain your answer: _____

   Is this Applicant working for the Employer? ☐ Yes ☐ With restrictions ☐ Without restrictions ☐ No

4. **If the Applicant is working for the Employer:**

What is the Applicant's position? _____

What are the Applicant's job restrictions?

_____

_____

If the Applicant is working with restrictions, how long will the position be available?

_____

If the Applicant is not working for the Employer:
Is there work available that the Applicant can perform that is within the Applicant's restrictions? ☐ Yes ☐ No

Describe the work that is available: _____

Were reasonable accommodations offered to the Applicant? ☐ Yes ☐ No

If yes, what reasonable accommodations were offered to the Applicant?

_____

_____

What were the results of the reasonable accommodations?

_____

_____

If no, explain why the Employer did not offer reasonable accommodations:

_____

_____

5. **What job duties is the Applicant unable to perform due to a disabling condition?**

_____

_____

_____

_____

6. **Please share any additional information you believe important in the consideration of this application.**

_____

_____

_____

_____

If more space is needed, please attach an additional sheet
Required Documents:

The Employer must attach
- Pre-Employment physical report
- All First Reports of Injury for Applicant
- It the onset of the illness/injury occurred within the last 2 years, attach a copy of the Applicant's position description for the position held when the applicant became disabled
- If the illness/injury occurred more than 2 years ago, attach a copy of the Applicant's position description for the last 90 days actually worked.

Employer's Signature

By:_____(Please type or print) Position:_____

Signature: _____ Date: _____

PUBLIC EMPLOYEES RETIREMENT ASSOCIATION
60 Empire Dr., Suite 200; St. Paul, MN 55103-2088
Telephone: 651-296-7460; or toll free 1-800-652-9026

CERTIFICATION BY GOVERNMENTAL UNIT REGARDING DISABILITY

IMPORTANT NOTE: Applicant is required by law to exhaust all accrued sick leave, which is subject to PERA deductions. If applicant elects to take a lump-sum payment for all accrued vacation time, no PERA deductions will be due on the lump-sum vacation pay. The fact that an employee is placed on a leave of absence without compensation because of disability shall not bar the employee from receiving a PERA disability benefit.

1	Employee Name	Employee PERA ID	Employer Name
	Employee Position/Title		
	Employee has been continuously employed since:		Last day physically on the job:
2	Final day on the payroll (the last day the employee was paid for using and exhausted their vacation, sick, donated time, and/or paid medical leave). This date must fall between the pay period begin and end date of the last payroll submitted for this employee.		
3	Has the employee terminated employment? (Termination is not required to be eligible for disability benefits) Yes____ If yes, indicate date_____ No ____		
4	Was the employee disabled as a direct result of employment? Yes____ If yes, include a copy of the injury report No ____		
5	Has the employee made claim for Worker's Compensation Payments? Yes____ No_____		
6	Is the employee receiving Worker's Compensation Payments? Yes_____ No____ Denied____ If yes, name of Insurance Carrier Contact Name Phone _____ _____ _____ Amount Paid Weekly $_____		
7	What was the salary of the employee at the time of disability? Base Hourly $_____ Base Weekly $_____ Base Monthly $_____ Annual Hours Worked _____ If the employee were still employed, what would their salary be today $_____ per_____		

Certification

I hereby certify that, to the best of my knowledge and belief, the information given here is true and correct according to the official records of this governmental subdivision.

Printed Name and Title	Email Address	Phone Number
Signature		Date
		Fax Number

Rev. 01/2018