

DISABILITY BENEFIT APPLICATION

Ohio Public Employees Retirement System 277 East Town Street, Columbus, Ohio 43215-4642 1-800-222-PERS (7377) www.opers.org



Please complete this form in its entirety. Failure to complete this form in its entirety could result in a delay in processing. All pages of this form are required to be returned for it to be considered a completed form. OPERS' third party administrator, may be contacting you regarding your application for disability benefits.

STEP 1: Member's Personal Information	This section is required to be completed or the form will be invalid.		
Social Security Number	OPERS ID		
	-OR-		
First Name	MI Last Name		
Date of Birth	Gender		
	O Male O Female O Prefer Not To Say		
Address			
City	State ZIP Code		
Home Phone Number	Work Phone Number		
Cell Phone Number			
Preferred Telephone Number for Contact:	Preferred Time to Call:		
	O Morning O Afternoon O Evening		
E-mail Address			

STEP 2: Member's Physician Information If you have multiple physicians, each physician must con behalf. The physician must be a licensed and practicing information. Please notify us if a physician you have ind	physician (MD o	r DO). It is importan	t to provide con	tact	
Physician Name		Submitting a DR-AF			DO
				ND	DO
Physician Office Mailing Address					
City		State	ZIP Code		
		State			
Physician Office Phone Number	Fax Numbe	r			
			_		
Will this physician be submitting a <i>Report of Physician</i> for	m (DR-APS)?	○ Yes ○ No			
Physician Name (2)				MD	DO
Physician Office Mailing Address					
City		State	ZIP Code		
Physician Office Phone Number	Fax Numbe	r			
		_	—		
Will this physician be submitting a <i>Report of Physician</i> for	m (DR-APS)?	⊖Yes ⊖No			
Physician Name (3)				MD	DO
Physician Office Mailing Address					
City		State	ZIP Code		

Will this physician be submitting a *Report of Physician* form (DR-APS)? OYes ONo

Physician Office Phone Number

Fax Number

STEP 3: Social Security Disability Insurance This section is required to be completed or the form will be invalid.

If you are approved for an OPERS Disability Benefit and you are eligible to apply for Social Security Disability Insurance (SSDI), you are required to apply, and provide a copy of the SSDI benefit application, not later than 90 days from the OPERS Board of Trustees approval date of your disability benefit application. This requirement does not apply to members in the OPERS law enforcement division. If you are not sure if you are eligible for an SSDI benefit you can find out by going to ssa.gov or by contacting Social Security at 1-800-772-1213.

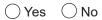
Are you currently receiving a Social Security Disability Insurance benefit?



Are you eligible to apply for a Social Security Disability Insurance benefit?

⊖Yes ⊖No

Do you have at least five years of OPERS service credit for the same periods during which you had earnings from other employment that was taxable under Social Security (FICA tax) for any time period prior to your application for disability benefits?



STEP 4: Other Retirement System Service Information

If you are currently a member or have been a member of any of the following retirement systems, please complete the following. If you have never been a member of one of the retirement systems listed below, please check this box:

	Currently a member?	Have bee	en a member?
Ohio Police and Fire Pension Fund (OP&F)		or	
State Highway Patrol Retirement System (HPRS)	or	
Cincinnati Retirement System (CRS)		or	
State Teachers Retirement System (STRS)		or	
School Employees Retirement System (SERS)		or	

If you have refunded from either STRS or SERS, are you interested in purchasing this time to be included in the calculation of your benefit?

⊖Yes ⊖No

If you have membership with SERS and/or STRS, this credit may be used in the calculation of your OPERS benefit or you may elect to retire on an independent basis using only OPERS service and salary.

NO, DO NOT combine my SERS and/or STRS account with my OPERS account

YES, DO combine my SERS and/or STRS account with my OPERS account

STEP 5: Other Service Information

Are you in the process of, or planning to, purchase service credit?

If yes, what type?

STEP 6: Rehabilitative Services

OPERS offers Rehabilitative Services to our disability benefit recipients to assist them with maximizing their functionality and employability. Please choose one of the following options.

If my application is approved, I choose to actively participate in Rehabilitative Services. I understand that by actively participating in Rehabilitative Services I will remain on a leave of absence from my last public employer and continue to be evaluated under the **own occupation** standard for up to five years following the effective date of my benefit. If at any time after my third benefit anniversary I stop participating in rehabilitative services, my disabling condition will be reviewed immediately under the **any occupation** standard. Furthermore, I understand that upon the expiration of my leave of absence period I will be evaluated under the **any occupation** standard.

-OR-

If my application is approved, I choose not to participate in Rehabilitative Services. I understand that by not actively participating in Rehabilitative Services my leave of absence from my last public employer will be limited to three years following the effective date of my benefit. Furthermore, I understand that upon the expiration of my leave of absence period I will be evaluated under the **any occupation** standard.

STEP 7: Banking Information			
Bank Name			
Bank Address			
City		ZIP or Postal Code	
State or Province		Country	
Bank Routing Number	Account Number		
(Choose only one)	Example Check > Valid routing numbers begin with 0,1, 2 or 3		
◯ Checking -OR- ◯ Savings	110120450781 1102	" 1240120450"	
	Bank Routing Number	Account Number	

STEP 8: Member's Authorization and Acknowledgment

This section is required to be completed or the form will be invalid.

Being duly sworn, I, the undersigned, state that the information I provided in this Application is complete and true to the best of my knowledge and belief.

I understand that, by applying for disability benefits, I am consenting to undergo medical examinations by an OPERSappointed, independent medical examiner(s) and authorize my physician(s) to provide OPERS with my medical information.

I acknowledge that, if my application is approved, I must terminate public employment not later than the month following the month in which the OPERS Board approves my application.

I acknowledge that if I do not terminate public employment within this time frame, my application will be void, my disability benefit will not be paid and will be forfeited, and, if I am eligible, I may file a new disability application.

I acknowledge that I have received and reviewed the OPERS Disability Benefits leaflet and the Member Handbook concerning disability benefits. If I am approved by the OPERS Board for disability benefits, I acknowledge that this approval may be contingent upon my receiving continued medical treatment for my disabiling condition.

Additionally, I acknowledge that my disability benefits will be terminated should I return to public employment or service as an elective official.

Member Signature _____

Do not print or type name

_Today's Date____/

