COAERS
CITY OF AUSTIN
EMPLOYEES' RETIREMENT SYSTEM

Disability Retirement Application
Instructions & Important Information

To be eligible for disability retirement benefits with COAERS, you must meet all four of the following conditions:

1. Be an active-contributing or inactive-contributing member or be on approved medical leave of absence;
2. Have a minimum of five years Creditable Service in COAERS unless the disability is the direct result of an on-the-job injury/illness with the employer (City or COAERS) after your effective date of membership;
3. Be physically or mentally incapacitated for the performance of ALL employment duties;
4. Have an incapacitation for all job duties that is expected to be permanent.

If you are terminated from employment for an inability to perform all employment duties, you must make application for disability retirement benefits within 90 days of termination.

What documents are required to apply for COAERS disability retirement benefits?
You must submit the following documents to apply for COAERS disability retirement:

- *"Member Statement - COAERS Disability Retirement Application" (see attached.).* Your original Member Statement must be notarized. A Power-of-Attorney (POA) or Guardian may complete the Member Statement, as long as COAERS also receives the original POA or Guardianship documentation.
- *"Physician Statement - COAERS Disability Retirement Application" (see Attachment A.2.)* ***ALL*** physicians treating you for the disabling condition since the onset of the illness or injury must complete a Physician Statement. You must sign the *"Request and Legal Release from Member*" section on the front page of the *Physician Statement* authorizing release of your medical records *prior* to submitting the form to each physician. Statements must be from an M.D. (family practitioner or medical specialist) or D.O. (osteopathic medicine); statements from chiropractors will be insufficient. All *Physician Statement* must be original, legible and, answered fully.
- A complete copy of **all** your medical records is required, including all notes, narrative reports, and test results from **all** physicians treating you since the onset of the illness or injury.

It is your responsibility to submit full and complete information at your own expense. Copies of medical records provided to COAERS become the property of COAERS. In addition, please be advised that you may be requested to provide additional information and/or obtain examination(s) by a physician(s).

How do I submit my disability paperwork?

Contact Michelle Mahaini using the information below for instructions on how to submit your disability application. Do not email the application to Michelle.

(512) 458-2551 ext. 150
michelle.mahaini@coaers.org

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What's involved with the disability retirement application process?
Once COAERS receives the disability application and supporting documentation, a third-party Medical Consultant will review the materials and submit a written opinion to the COAERS Board of Trustees advising, in professional opinion, whether your disability condition meets the standard of disability in the COAERS governing statute.

Generally, the Benefits and Services Committee of the Board of Trustees will consider and recommend action on a disability retirement application at a regularly scheduled meeting.

The Benefits and Services Committee of the Board of Trustees, in its sole discretion, will make a recommendation to the Board to approve or deny your application, based on the statements, records and evidence submitted. You will be notified in writing of the decision. If the Board approves your disability retirement application, you will continue the retirement process with a COAERS Member Services Specialist. If the Board denies your disability application, COAERS will notify you of the appeals process.

If COAERS receives a disability retirement application on the basis of mental incapacity, or if records and evidence suggest mental incompetence, the Board may require the appointment of a Guardian. In this case, the Guardianship may be required to take effect before competing the disability retirement process.

Are there more requirements after I begin receiving my disability benefits?
COAERS requires disability retirees to provide proof of continued eligibility to receive disability retirement benefits. This can include tax records, employment records, and income documentation. In addition, COAERS may require additional examinations by a physician if deemed necessary. The Board of Trustees has the right to request financial reviews and order medical examinations of any disability retiree until they reach normal retirement age.

Will COAERS disability benefits affect other benefits I receive?

Check with your disability insurance provider (e.g., Short- and Long-Term Disability coverage) to determine how disability retirement from COAERS may affect the amount you receive from this benefit.

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Member Statement
COAERS Disability Retirement Application

This statement must be made by the COAERS member applying for disability benefits. A Power-of-Attorney (POA) or Court appointed Guardian may complete and submit this statement, provided original documentation of the POA or Guardianship is included. All questions must be answered fully. Additional pages may be attached as needed for any response. Corrections must be initialed. COAERS reserves the right to reject the form if it is not legible.

Name: _____
Department: _____
Phone: _____
Email: _____

Complete the following information.

1. Job Title of Your Current Position: _____

2. Job description (specific activities): _____
   _____
   _____

3. Last day worked due to disability: _____

4. Provide the job titles and employers for your last 10 years of work experience:
   _____
   _____
   _____

5. Indicate your education and training:

	Years/Hours completed	Graduated	Location
Elementary school			
High school			
College			
Specialty school			
Technical school			

6. Describe your medical problem(s), by answering the following questions:
   a. What is the ***medical diagnosis*** that limits your work? _____
      _____
   b. How did the injury or illness occur? _____
   c. Date injury or illness first occurred? _____

d. What types of activity bother you most? _____
_____

e. What specific activities does this injury or illness prevent you from doing? _____
_____

f. Did you have any previous difficulty with the same problem?
☐ Yes ☐ No
Explain and provide dates you experienced the same problem:
_____
_____

7. If your disability is job related, describe how you were injured and when:
_____
_____
_____

8. Do you feel your condition is stable, improving, or getting worse?
_____
Please explain: _____
_____

9. What normal activities are prevented by the claimed disability?
_____
_____

10. Have you engaged in or applied for any employment other than with the City of Austin or COAERS during the past year?
☐ Yes ☐ No
Please explain: _____
_____

11. Have you undergone or are you currently participating in vocational/physical therapy rehabilitation?
☐ Yes ☐ No
If yes, explain: _____
_____

12. Have you undergone or are you currently participating in any job or vocational training?
☐ Yes ☐ No
If yes, explain: _____
_____

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13. List ALL physicians consulted for ***this*** medical problem and include the dates of treatment *(NOTE: Completed physician statements and copies of **all** medical records must be submitted from each of these physicians.)*:

Name	Mailing Address	Date

14. List ALL physicians who have treated you for ***any other*** medical problems (e.g. diabetes, high blood pressure, heart problems, etc.) during the past two years, other than those listed above, including medical diagnosis and dates of treatment *(NOTE: Copies of **all** medical records must be submitted from each of these physicians)*:

Name	Mailing Address	Diagnosis	Date

15. List all hospitalizations and operations:

Hospital	Treatment or Operation	Date

16. List names of all medicines and daily dosage you currently take and the name of the prescribing doctor:

Medicine	Dose Per Day	Condition being treated	Prescribing Doctor

17. Have you followed all your doctor's recommendations?
    ☐ Yes ☐ No
    If no, explain: _____
    _____

18. You may be entitled to disability retirement benefits if you are mentally or physically incapacitated for performance of all employment duties and the incapacity is likely to be permanent. You must be either an active-contributory member, an inactive-contributory member, or be on approved medical leave of absence.
    a. Are you still employed with the City of Austin or COAERS or have you been terminated 90 days or less for your inability to perform your employment duties? ☐ Yes ☐ No

    b. How long is your disability expected to continue? _____
    _____

    c. What changes are expected relative to your disability? _____
    _____

19. The COAERS Board may, as appropriate, require that a Guardian be appointed for a member in cases where it has been represented or evidence shows that the member is mentally incompetent, or the member has applied for disability on the basis of mental incapacity. Such Guardianship is required prior to processing the disability retirement and disbursement of the retirement annuity payments. Do you feel that you are competent and capable of handling your personal affairs?
    ☐ Yes ☐ No

20. Provide any other facts or medical information you feel would support your request for disability retirement (attach additional pages if needed):
    _____
    _____
    _____
    _____
    _____
    _____
    _____

    ****

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Read and then sign this page in front of a notary.

I, the undersigned, do hereby make and submit this application required for disability retirement benefits and upon my oath do state that I am above the age of 18, that I am a member of the City of Austin Employees' Retirement System, and that I expressly waive all provisions of law prohibiting any physician and any other person who has attended me from disclosing any knowledge or information that they acquired.

I hereby consent to and authorize my physician(s) to release a complete copy of my medical record, including all notes, narrative reports, and test results to the City of Austin Employees' Retirement System. I authorize the release of employment records including, but not limited to, job descriptions and personnel history, workers' compensation records, reports of accidents, and physician letters and reports.

I hereby consent to and authorize the City of Austin Employees' Retirement System to release medical information, which it has or may have, to any physician for the purpose of reviewing and making a recommendation on this application. Further, I hereby expressly consent to the release of all medical information concerning my condition to any medical consultant/vocational rehabilitation specialist selected by the Board of Trustees of the City of Austin Employees' Retirement System.

I further certify the above statements were made by me or on my behalf, that they are complete and true to the best of my information, knowledge, and belief, and that they are made for the purpose of securing disability retirement benefits, in compliance with the disability provisions of Art. 6243n., Tex. Rev. Civ. Stat., and the System's rules, regulations, and policies. I understand that any misstatement, misrepresentation, or omission of fact could result in denial, suspension, or termination of disability retirement benefits. I also understand that falsification of any information or record or the acquiescence in falsification of any information or records submitted to the System is deemed a Class B Misdemeanor and may result in criminal charges being pursued. I understand that it is my responsibility to submit evidence of total and permanent disability due to my being mentally or physically incapacitated for the performance of all employment duties. I also agree that a copy of this authorization will be considered as effective and valid as the original.

Member's Printed Name	
Member's Signature	**Date**

NOTARY

State of_____County of _____ Before me, the above named individual personally appeared and he/she is known to me to be the person whose name is subscribed to the foregoing instrument and acknowledged to me and executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this_____day of_____, 20_____.

Notary Public's Signature: _____

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Physician Statement
COAERS Disability Retirement Application

The City of Austin Employees' Retirement System (COAERS) is respectfully asking for your professional opinion to help us decide whether the patient named below is eligible for disability retirement benefits. We appreciate your time and attention to this matter as it is of importance to the patient and to the Board of Trustees and staff of COAERS.

Patient Information

Name: _____

SSN: ***-**-_____

Patient Release

I am applying for permanent disability retirement benefits from the City of Austin Employees' Retirement System (COAERS). Please furnish a *complete* copy of my medical records, including all notes, narrative reports, and test results, to accompany this Physician Statement.

_____ _____

Patient Signature **Date**

Physician Information

Name of Attending Physician	**Address**
Physician's Area of Expertise or Specialty	**Board Certification (List all applicable certifications)**

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1. Diagnosis of Disability (do not use Diagnosis codes):

   _____
   _____

2. a. Date of onset: _____
   b. Date of first visit to your office for this disability: _____
   c. Date of last examination: _____
   d. Are you still attending the member?
   ☐ Yes ☐ No

3. Briefly describe etiology, severity, course of disorder, treatment, response to treatment, and other significant details pertinent to your diagnosis. Please use the back of the form or attach additional sheets if necessary.

   _____
   _____
   _____
   _____

4. Give findings, whenever available, regarding:
   a. Height: _____ft. _____in.
   b. Weight: _____lbs.
   c. Blood pressure: _____
   d. Pulse: _____
   e. Respiration: _____
   f. Temperature: _____

5. Give ***abnormal*** findings to support diagnosis: (Use reverse side if necessary)
   a. Head and Neck and ENT: _____
   b. Chest: _____
   c. Heart: _____
   d. Abdomen: _____
   e. Extremities: _____
   f. Neurological: _____
   g. Psychiatric: _____
   h. Laboratory (copies required): _____
   i. Special tests (copies required): _____

6. List additional diagnoses or medical problems of this patient:

Diagnosis	***Dates***

7. What medications and doses are you prescribing for this patient?

   _____
   _____

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8. In your opinion, is this patient competent and capable of handling their own personal and financial affairs?
   ☐ Yes ☐ No

9. Has this patient been compliant with your care and advice?
   ☐ Yes ☐ No

10. Describe physical and/or mental/cognitive limitations of patient: _____
    _____
    _____

11. From present indications, what seems to be the most probable course of this patient's illness or injury?
    _____
    _____

12. According to the provisions of the City of Austin Employees' Retirement System, a member of the COAERS is entitled to disability retirement benefits provided the member is mentally or physically incapacitated to engage in ***all employment duties*** (not just their City of Austin job duties) and that such incapacity is likely to be ***permanent.*** In your opinion, does the disability ***completely*** prevent the patient from engaging in ***any and all*** employment duties?
    ☐ Yes ☐ No
    If yes, please skip questions #13 and #14

13. In your opinion, what type of job duties could this patient perform?
    _____
    _____

14. In your opinion, is your patient able to be employed in some sedentary work activity?
    ☐ Yes ☐ No

15. Please provide any additional pertinent remarks/information/insights:
    _____
    _____

I, the undersigned, do certify that the above statements and answers were made by me, and that said statements and answers are each and all complete and true to the best of my knowledge, information, and belief. I am licensed to practice medicine in the State of Texas.

Name of Attending Physician	**Signature of Attending Physician**
Address	**Date Signed**
City State Zip	**Phone Number**
Area of Expertise/Specialty	**Board Certification (List all applicable)**