In order to apply for disability benefits, you must complete the questions and forms contained in this application. This application consists of:

- Information and answers you must provide ......................... pages 1–14
- Authorizations for release of information
  - Insurance records ................................................................. 15
  - Protected health information ............................................. 16
  - Tax records ................................................................. 17
- Medical Panel selection form ........................................... 18

Before you begin to fill out this application, please refer to our booklet, What You Should Know About Disability Retirement, for general information and eligibility requirements regarding disability retirements. If you have any questions or need clarification, please contact our Disability Case Manager for help.

Do not delete any pages from this application. If necessary, please attach additional sheets.

As required, please print your responses legibly, in ink.

The ✓ symbol means that you must submit the document listed in the margin along with your application.

Be sure to complete the entire application, including the release forms, and attach all required documents before returning your application to our office. If your application is incomplete, we will return it to you and this will delay processing. We cannot assign a date of application—which is very important in determining the effective date of your retirement if your application is approved—until you have submitted all required information.

Before you send the application and your documents to us, make a photocopy of all pages for your records.

After you have completed this application, gathered the required documents and made a photocopy for your records, please send your materials to:

Disability Case Manager
Massachusetts Teachers’ Retirement System
One Charles Park
Cambridge, MA 02142-1206
Applicant data

☐ Type of disability retirement applied for □ Accidental □ Ordinary □ Both

☐ Social Security number, XXX-XX-XXXX

☐ Gender □ Male □ Female

☐ Name

☐ Former/maiden name, if applicable

☐ Date of birth □ , mm/dd/yyyy

☐ Mailing address

☐ Home phone (_____) __________________________ E-mail __________________________

☐ Marital status □ Married □ Single □ Divorced □ Widowed

☐ Veteran status □ Nonveteran □ Veteran

☐ Dates of active military service: mm/yyyy From _____ to _____

☐ Total year(s) _______________

☐ MTRS RetirementPlus status □ Nonparticipating □ Don't know

□ Participating (elected in)

□ Participating (mandated)

Alternate address: 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 below.

Alternate address

☐ Date here: From _____ to _____ mm/yyyy mm/yyyy

Attorney data

If applicable

☐ Name

☐ Firm

☐ Address

☐ Phone (_____ ) __________________________ Fax (_____ ) __________________________
I, ________________________________________, hereby make application for disability retirement benefits pursuant to Massachusetts General Laws, c. 32, sections 6 or 7.

The incapacity described is not the result of serious or willful misconduct on my part.

If I am applying for accidental disability benefits, I state that the incapacity described herein and in the written materials accompanying this application, was sustained as a result of an injury or hazard that I underwent as a result of my employment and while in the performance of my duties.

I do hereby certify that this statement, together with the statements made herein and on the written materials accompanying this application, are made under the pains and penalties of perjury and are true and accurate to the best of my knowledge and belief. I acknowledge that this application is made subject to the criminal forfeiture provisions of G.L. c. 32, section 15 and the other requirements and provisions of applicable law, including Chapter 32 of the Massachusetts General Laws and titles 807 and 840 of the Code of Massachusetts Regulations.

Applicant’s Signature ___________________________________________________ Date ______________________

Current position (position you are retiring from)

Title ___________________________________________________________________________________

School district ______________________________ Grade(s) taught ___________________________

Dates employed From _______________ to _______________ Date when you last worked _________________

School _________________________________________________________________________________

Phone (________)_________________________________ Fax (________) __________________

Name of superintendent ___________________________________ Phone (________) __________________

Name of principal_________________________________________ Phone (________) __________________

Name of immediate supervisor ______________________________ Phone (________) __________________

Creditable service estimate

Please indicate your approximate number of years of creditable service. ................... ______________
All Previous Employment

Please list all previous employment in chronological order, beginning with your oldest position and ending with your current position. If you have ever been employed by any other Massachusetts state governmental agency or unit, you may be eligible to purchase creditable service for that employment. If you list the Commonwealth of Massachusetts as a previous employer, please check the box in the last column (MA public service).

<table>
<thead>
<tr>
<th>Period of employment From (mm/dd/yyyy)</th>
<th>To (mm/dd/yyyy)</th>
<th>Employer’s name/address</th>
<th>If MA public service, please check box</th>
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</table>

We will be requesting a statement certifying your disability status from the physician who is treating you for your disability. Please list the physician who has provided you with primary care in connection with your disability and from whom we should request this statement. We recommend that you contact this physician to notify him or her that the MTRS will be sending him or her a Physician’s Statement form to complete. We will send you a copy of the completed Physician’s Statement form.

[Note: If you are applying for disability retirement based on more than one condition, you must list one primary physician for each condition. If this applies to you, please check the box, below, and attach a separate sheet.]

Primary treating physician

Primary treating physician’s name ____________________________________________________________

Last ____________  First ____________  Middle ____________

Address __________________________________________________________

Number and street___________  City ____________  State ____________  ZIP ____________

Phone (__________) ____________________________

Additional condition(s) and primary physician(s): Please see attached sheet for additional physician listing(s).
Disability and duties

- Please state the medical reason which is the cause of your application for disability.

- Please describe the essential duties which you are required to perform in your current position.

- How frequently are you required to perform the essential duties you described above?

- Please describe the essential duties which you are unable to perform as a result of your disability.

Recent physical activities

- For the period of the last year, please describe your physical activities, including:
  
  Medical rehabilitation activities

  Other employment activities since the onset of your disability

  Sports activities

  Activities of daily living (for example, driving, cleaning, etc.)
We advise that you read this section carefully. It concerns the right of the MTRS to offset your disability retirement pension benefit by the amount of certain outside payments you may receive for the same injury.

Pursuant to Massachusetts General Laws, chapter 32, s. 14(2), the MTRS has the authority to offset from your disability pension the following payments you may receive as a result of the same injury for which you receive a disability pension:

- Any and all Workers’ Compensation disability payments which you receive under Massachusetts General Laws, chapter 152, ss. 31 (survivor’s benefits), 34 (temporary total), 34A (permanent and total), 34B (COLA), 35 (temporary partial) and 35A (dependent’s benefits).
- Any recovery for lost wages you may receive from a third party other than your employer.

The statute also requires that you cooperate with the MTRS both in filing for and receiving Workers’ Compensation benefits and pursuing and reporting any third party payments. If you do not cooperate in this regard, the MTRS has the authority to suspend your disability pension and/or file for Workers’ Compensation or other benefits on your behalf. **Please note: You are required to notify the MTRS as to any change in rate of your Workers’ Compensation benefit (including, but not limited to changes in COLA) or prior to any settlement of your Workers’ Compensation or third-party (i.e., personal injury) claim. Failure to do so may result in an overpayment for which you will be liable.**

- Have you **applied for** Workers’ Compensation benefits? ................. □ Yes □ No
  - If “yes,” date you applied for Workers’ Compensation, mm/dd/yyyy … ______________
  - If “no:”
    - Please be aware that you must apply for Workers’ Compensation benefits.
    - Are you applying for an accidental disability retirement? ............. □ No □ Yes

- Have you **received** or are you **receiving** Workers’ Compensation benefits or a settlement? ........................................................ □ No □ Yes
  - If “yes,” please provide the following information:
    - Type of Workers’ Compensation receiving or received ......................... □ Weekly benefits □ Settlement ✓
    - Date of initial payment, mm/dd/yyyy ..........................
    - Amount of payment as part of a weekly/biweekly benefits or settlement. ..................
    - Type of incapacity .................................................. □ Total □ Partial
    - Receiving workers’ compensation COLA? If so, please provide the date you first received a COLA.
    - Name of attorney for Workers’ Compensation Insurer ..........................
    - Name and phone number of the Workers’ Compensation insurance adjuster/claims representative for the school district/town or, if self-insured, name and phone number of the Workers’ Compensation agent for the school district/town. ..........................................................
      (_______)___________________________

- Copy of your settlement agreement

Form LEG-F0010-DRA-10212008
In order for us to calculate your potential disability retirement benefits, we need information regarding your regular compensation. Please report either your three highest consecutive years’ regular compensation or your last three years’ regular compensation, whichever is greater. Please note:

- Please report your contracted salaries for four school years.
- You must submit copies of your contracts verifying your regular compensation listed here. Be sure to include payment schedules or contractual language to substantiate any earnings in excess of your regular contract rates.

<table>
<thead>
<tr>
<th>School Year</th>
<th>From</th>
<th>To</th>
<th>Regular Compensation</th>
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</thead>
<tbody>
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- As of the date of this application, what is your salary status? 
- Paid leave
- Sick bank
- Unpaid leave
- Workers’ Compensation

If you are a veteran, please also list your regular compensation for the last 12 months.

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<tr>
<th>School Year</th>
<th>From</th>
<th>To</th>
<th>Regular Compensation</th>
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</table>

If your application for disability retirement benefits is approved, you may choose to receive your payment under Option A, B or C. If you are considering Option C—which allows for a monthly survivor benefit—you must provide the following information regarding your beneficiary. By completing this section, you are not choosing Option C, you are simply providing us with the information necessary to calculate the Option C benefit. Note:

- Under Option C, your beneficiary must be your parent, sibling, child, spouse or former spouse who has not remarried.
- You must also submit your beneficiary’s certified birth record.
- If your beneficiary is your spouse or a former spouse who has not remarried, you must also submit a copy of your marriage certificate.

- Name __________________________________________________________________________________
  Prefix First MI Last Suffix
- Date of birth ____________________
- Social Security number ___________
- Relationship to applicant:  □ Mother  □ Sister  □ Child  □ Spouse  □ Former spouse who has not remarried
- Certified birth record
- If spouse or former spouse, marriage certificate (photocopy OK)
Please record the names, birth dates and Social Security numbers of your children who are:
- under age 18;
- over age 18 and under 22 who are full-time students; and
- over age 18 and physically or mentally incapacitated from earning.

<table>
<thead>
<tr>
<th>Name (first MI last)</th>
<th>Gender</th>
<th>Date of birth (mm/dd/yyyy)</th>
<th>Social Security number</th>
<th>Status (check one)</th>
</tr>
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<td>Under 18</td>
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<td></td>
<td></td>
<td></td>
<td>Student 18–22</td>
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<td>Incapacitated over 18</td>
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<td>□ M □ F</td>
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</tbody>
</table>

- If you are applying for retirement based on:
  - **Ordinary disability only**, skip to page 13 (Medical history).
  - **Accidental disability only, or both accidental and ordinary disability**, please continue on page 8.
One of the conditions for receiving approval of your application for accidental disability retirement benefits is that the Board must find that the disability is the natural and proximate result of either

- the personal injury you sustained (usually, one or several specific incidents) or
- the hazard undergone (generally, exposure to a harmful situation over a period of time).

Please identify the reason for your disability . . . . . . .

☐ Personal injury sustained  ☐ Hazard or exposure undergone

Being as specific as possible, please describe either the personal injury you sustained or the hazard/exposure undergone

☐ Date(s) ______________________________________________________________________________

____________________________________________________________________________________

☐ Specific time(s) or if hazard/exposure, length of time exposed __________________________________

____________________________________________________________________________________

☐ Location(s) ___________________________________________________________________________

____________________________________________________________________________________

☐ Description of incident(s) or hazard/exposure _____________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Please describe the job duties you were performing immediately prior to and during the time of the personal injury you sustained or the hazard/exposure undergone

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
### Witness data

- Did anyone witness the incident(s) or hazard/exposure described above?  
  - [ ] No  
  - [x] Yes  
- If “yes,” please provide the following information for each witness:

<table>
<thead>
<tr>
<th>Name</th>
<th>Last</th>
<th>First</th>
<th>MI</th>
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</thead>
<tbody>
<tr>
<td>Address</td>
<td>Number and street</td>
<td>Apt.</td>
<td>PO Box</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>ZIP</td>
<td></td>
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<tr>
<td>Phone (_____)</td>
<td>Relationship to applicant</td>
<td></td>
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<table>
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<tr>
<th>Name</th>
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</tr>
<tr>
<td>Phone (_____)</td>
<td>Relationship to applicant</td>
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</table>

### Incident reports

- Have you filed a report of the incident(s) or hazard/exposure described above with any person or agency?  
  - [ ] No  
  - [x] Yes  
- If “yes,” please provide the following information for each person or agency:

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<tr>
<th>Name</th>
<th>Last</th>
<th>First</th>
<th>MI</th>
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<tbody>
<tr>
<td>Agency</td>
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<tr>
<td>Address</td>
<td>Number and street</td>
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<tr>
<td>City</td>
<td>State</td>
<td>ZIP</td>
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<tr>
<td>Phone (_____)</td>
<td>Date report filed</td>
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<th>Name</th>
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<td>Phone (_____)</td>
<td>Date report filed</td>
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- [✓] Claim or incident report
Insurance coverage

Do you have any insurance coverage which relates to the incident(s) or hazard/exposure described above? ☐ No ☐ Yes

If "yes," please provide the following information for each policy. Additionally, please note: The MTRS requires that you sign an Authorization for the release of insurance records. This form is on page 15 and allows the MTRS to request copies of your insurance records from the insurers you list below for the period of the last five years.

Agent’s name ____________________________________________________________________________
Last First MI
Agency _______________________________________________________________________________
Address ________________________________________________________________________________
Number and street
_________________________________________ City State ZIP
Phone (______) _____________________ Type of coverage ________________________________

Agent’s name ____________________________________________________________________________
Last First MI
Agency _______________________________________________________________________________
Address ________________________________________________________________________________
Number and street
_________________________________________ City State ZIP
Phone (______) _____________________ Type of coverage ________________________________

Emergency medical treatment

Did you receive emergency medical treatment as a result of the incident(s) or hazard/exposure described above? ☐ No ☐ Yes

If "yes," please provide the following information for each physician from whom you received treatment. Additionally, please note: The MTRS requires that you sign an authorization for the release of protected health records. This form is on page 16 and allows the MTRS to request copies of your medical records from the facilities and physicians you list below.

Treating physician’s name __________________________________________________________________
Last First MI
Hospital/facility __________________________________________________________________________
Address ________________________________________________________________________________
Number and street
_________________________________________ City State ZIP
Phone (______) _____________________ Date(s) of treatment _____________________________

Treating physician’s name __________________________________________________________________
Last First MI
Hospital/facility __________________________________________________________________________
Address ________________________________________________________________________________
Number and street
_________________________________________ City State ZIP
Phone (______) _____________________ Date(s) of treatment _____________________________

Form LEG-F0010-DRA-10212008
Medical treatment

- Have you received any medical treatment as a result of the incident(s) or hazard/exposure described above? □ No □ Yes
  - If “yes,” please provide the following information. Additionally, please note: The MTRS requires that you sign an authorization for the release of protected health records. This form is on page 16 and allows the MTRS to request copies of your medical records from the facilities and physicians you list below.

- Primary care physician’s name
  - Last
  - First
  - MI
  - Address
  - Number and street
  - City
  - State
  - ZIP
  - Phone (___________)
  - Date(s) of treatment
  - Nature of treatment
    - 
    - 
    - 

- Primary care physician’s name
  - Last
  - First
  - MI
  - Address
  - Number and street
  - City
  - State
  - ZIP
  - Phone (___________)
  - Date(s) of treatment
  - Nature of treatment
    - 
    - 
    - 

- Did you take any time off from your employment? □ No □ Yes
  - If “yes,” please list date(s) and time(s)
    - 
    - 

- Did your physician(s) recommend any rehabilitation? □ No □ Yes
  - If “yes,” please describe any rehabilitation you have undergone
Other actions taken

- As a result of the incident(s) or hazard/exposure described above, did you file a grievance pursuant to your collective bargaining agreement? ............. ☐ Not applicable ☐ No ☐ Yes
  - If “yes,” please describe the status of your grievance __________________________________________
    ____________________________________________________________________________________

- As a result of the incident(s) or hazard/exposure described above, was any administrative or disciplinary action taken by your employer? .......... ☐ No ☐ Yes
  - If “yes,” please explain ________________________________________________________________
    ____________________________________________________________________________________
    ____________________________________________________________________________________

- As a result of the incident(s) or hazard/exposure described above, did your employer conduct any tests or studies on any area of the school building or grounds or make any repairs in such areas? ................. ☐ Not applicable ☐ No ☐ Yes
  - If “yes,” please explain ________________________________________________________________
    ____________________________________________________________________________________
    ____________________________________________________________________________________

Other conditions

- Contributing conditions or events

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

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________
The following sections relate to any medical treatment you have received.

### Prior illnesses, accidents or injuries

Please list all prior illnesses, accidents or injuries you have had, beginning with the oldest occurrence and ending with the most recent one.

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<tr>
<th>Date(s)</th>
<th>Description of illness, accident or injury</th>
<th>Medical treatment received</th>
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<td>From (mo/day/yr)</td>
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### Hospitals, medical facilities or institutions

Please list all hospitals, medical facilities or institutions which you have consulted or at which you received any treatment, beginning with the oldest occurrence and ending with the most recent one. Additionally, please note: The MTRS requires that you sign an authorization for the release of protected health records. This form is on page 16 and allows the MTRS to request copies of your medical records from the facilities you list below.

<table>
<thead>
<tr>
<th>Date(s)</th>
<th>Name of facility/address/phone number</th>
<th>Reason for visit</th>
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<tbody>
<tr>
<td>From (mo/day/yr)</td>
<td>To (mo/day/yr)</td>
<td>__________________________</td>
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Medical history
Continued

Physicians

Please list all physicians whom you have consulted or from whom you received any treatment, beginning with the oldest consultation and ending with the most recent one. Additionally, please note: The MTRS requires that you sign an authorization for the release of protected health records. This form is on page 16 and allows the MTRS to request copies of your medical records from the physicians you list below.

<table>
<thead>
<tr>
<th>Date(s)</th>
<th>Name of physician/ Address/ Phone number</th>
<th>Reason for consultation</th>
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As a result of time away from your employment, if any, because of your disability, have you

- taken any paid sick leave? □ Yes; from ___________ to ___________
- taken any paid vacation time? □ Yes; from ___________ to ___________
- taken any unpaid sick leave? □ Yes; from ___________ to ___________
- taken any unpaid leave? □ Yes; from ___________ to ___________

Paid and unpaid leaves

Note to applicant

Please continue on page 15. The release forms on the remaining pages must be completed by all applicants.
Applicant's statement and authorization for release of insurance records

To be completed by applicant

- Re: ____________________________
  Name of applicant/record subject

  Number/street

  City          State          ZIP

  Social Security number          Date of birth

- I authorize the MTRS to submit this release to, and to request my insurance records from, any insurer or agency I have listed in this Disability Retirement Application.

  Additionally, I understand that if the insurer or agency charges any fee for providing these records, I will be responsible for the payment of such fee. If I do not agree to pay, I understand that my application may not be processed.

  I authorize the below-named individual, insurer or agency to release to the Massachusetts Teachers' Retirement System any and all information, reports and records it may have regarding any application or claim for insurance I have made during the five (5) years preceding the date beside my signature, below. The scope of this authorization includes the release and copying of such information, reports and records, including but not limited to: correspondence, application forms, claim forms and medical examinations. A photocopy of this document, including my signature, shall be as valid and effective as the original.

  Signature ___________________________________________ Date __________________________

Request for insurance records

To be completed by MTRS

- **Keeper of the Records**

  Name of insurer and/or agency

  Number/street

  City          State          ZIP

  Name of record subject's employer/group          Policy/certificate number

- Date of request ____________________________

- **Please forward records by** ____________________________

- **To the Keeper of the Records:** You have been named as having provided insurance coverage by the above-noted individual in his or her application for disability retirement. In accordance with the above authorization, please submit your insurance records regarding this individual, by the forwarding date indicated, directly to:

  Disability Case Manager
  Massachusetts Teachers' Retirement System
  One Charles Park
  Cambridge, MA 02142-11206

  Please include a copy of this sheet with any records that you send us. If you have any questions, please contact the Disability Case Manager immediately at 617-679-6877. Thank you for your cooperation and assistance.
1. 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.

2. Patient Name: ___________________________________________    Date of Birth: ____________________
   Address: ________________________________________________________________________________
   Street                                                           City                                                            State                         Zip

3. Information to be disclosed to:  Massachusetts Teachers' Retirement System
   One Charles Park
   Cambridge, MA  02142-1206

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

   Authorize Release of Complete Medical Record

   Exceptions: ____________________________________________________________________________________
   ______________________________________________________________________________________

5. I have checked the box below indicating the purpose for the disclosure of this information.

   Disability Retirement Application: (G.L. c.32, §6 & §7)
   Restoration to Service Evaluation (including rehabilitation): (G.L. c.32, §8)
   Accidental Death Benefit: (G.L. c.32, §9 & §100)

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

7. This authorization will expire upon final determination of my disability application or Comprehensive
   Medical Evaluation/Rehabilitation/Restoration to Service process or up to one year from date signed
   below.

8. ____________________________                  10. ____________________________
   Signature of Patient or Legal Representative Date

9. ____________________________                        ____________________________
   Printed Name of Patient or Patient's Representative Relationship to Patient/Authority to Act for
   Patient if Applicable
Applicant’s statement and authorization for release of tax records

To be completed by applicant

- Re: ____________________________________________________________ Name of applicant/record subject

- Number/street

- City __________ State __________ ZIP __________

- Social Security number ___________________________ Date of birth ___________________________

- I understand that I am obliged to authorize the release of my tax records from the Federal Internal Revenue Service and/or the Massachusetts Department of Revenue. Additionally, I understand that if my application for disability retirement is approved by the MTRS, I will be required to authorize annual releases of my tax records to the MTRS by signing any release form(s) as required (IRS form 4506 and Public Employee Retirement Administration form WM 394). I also understand that my failure to provide such future authorizations may result in the suspension and/or termination of my disability benefits.

- Signature _____________________________________________ Date __________________________
Instructions to applicant

All applicants for disability retirement must complete this form. And, unless the MTRS denies your application as a result of an initial fact-finding hearing, you must have a medical panel examination. The Public Employee Retirement Administration Commission (PERAC) appoints all medical panels. No member can receive a disability retirement unless the medical panel certifies to the MTRS that the member is disabled, that the member's disability is likely to be permanent and, in the case of an accidental disability application, that the member's disability is causally related to employment. (If the acceleration of a pre-existing condition is as a result of an accident or hazard undergone in the performance of the member's duties, causation would be established.)

If and when your case is at this stage, we will request that PERAC convene a medical panel, taking into consideration the nature of disability claimed, the type of doctors you have recently seen and where you live. PERAC pays the fees of the physicians on the medical panel. The medical panel will consist of three doctors; by law, the physicians cannot be members in an associated practice. Prior to the examination, we will forward copies of your medical records to each of the physicians for their review.

You have the choice of having the three physicians appointed to the medical panel examine you:

- as a group, regional medical panel (in one examination at one place at one appointment time) OR
- individually (in three separate examinations, potentially at three different locations at three different times).

By way of this form, you are selecting the type of medical panel examination you want. The statute requires that medical panel examinations take place as soon as possible at a time and place that is convenient for all parties. If you select a group panel and the panel fails to meet within 60 days of its appointment by PERAC, then PERAC will automatically schedule three separate examinations. You can amend your selection at any time during the 60 days after the panel has been appointed.

Please complete the Applicant Data and Medical Panel Selection sections, below.

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Applicant data

- Type of disability retirement applied for... Accidental   Ordinary   Both Accidental and Ordinary
- Name
  - Last
  - First
  - Middle
- Current Address
  - Number and street
  - Apt.
  - PO Box
- City
- State
- ZIP
- Phone (__________) ____________________________
- SSN___________________________________

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Medical Panel selection

- I, the undersigned, having applied for disability retirement from the Massachusetts Teachers' Retirement System, understand that in order to receive approval of my application, I must be examined by a three-physician medical panel appointed by the Commissioner of the Public Employee Retirement Administration Commission. I hereby select the following type of medical panel (check one):
  - A regional medical panel (group exam)
  - Separate appointments (individual exams)

- I understand that:
  - If I do not select a type of medical panel, a group panel will automatically be assigned to examine me.
  - If I fail to appear at any of the scheduled medical appointments, my application may be denied by the MTRS.
  - If I am unable to attend a scheduled medical appointment, I must give the Commissioner of PERAC reasonable notice, and if I do not provide reasonable notice to PERAC, I may be responsible for payment for the appointment. I may request that the appointment be rescheduled, but I understand that the Commissioner ordinarily only reschedules appointments as a result of extenuating circumstances such as death in the member's family or hospitalization of the member. If the Commissioner denies my request for rescheduling and I fail to appear at the originally scheduled appointment, the MTRS may deny my application and notify me and all parties of its decision and appeal rights.
  - If I select a regional medical panel and the panel fails to meet within 60 days of its appointment, PERAC will schedule separate appointments with three physicians.
  - I may change the type of medical panel I have selected within 60 days of its appointment by PERAC; to do this, I must submit an amended Medical Panel Selection Form (available upon request) to the MTRS.

Applicant's signature_________________________________________ Date ______________________