Disability Pension Application

Public School Retirement System
of the City of St. Louis (PSRSSTL)
3641 Olive Street, Suite 300
St. Louis, MO 63108-3601
Phone: (314) 534-7444
Fax: (314) 371-0805

General Information

Please read this information carefully. If you have specific questions, contact PSRSSTL as shown above.

To begin the application process for disability pension benefits, you must provide the following forms and information to PSRSSTL. Forms must be completed, signed and dated. If you are mailing information to PSRSSTL, please make copies for your records.

- ✓ Disability Pension Application
- ✓ Physician Report of Disabling Condition Form **or** evidence that you have been approved for disability benefits under the federal Old Age, Survivors and Disability Insurance System of the Social Security Act (SSDI Benefits).

Your disability pension must be approved by the Board of Trustees.

Effective Date

If your application for disability pension benefits is approved, the effective date of your disability pension will be the later of the first of the month following 15 days after your completed Disability Pension Application was received by PSRSSTL or the first of the month following the last day for which you received compensation from your employer. To be considered complete, all sections of the Disability Pension Application must be filled out, signed and dated. We must receive all necessary information and completed forms prior to determining a disability pension effective date.

Amount of Benefit

The amount of your disability pension benefit will be the greater of (1) what your normal retirement benefit would be (computed as if you were age 65), or (2) one-fourth (¼) of your average final compensation; however, your disability pension benefit cannot exceed the retirement benefit you would have received at your Normal Retirement Age if you had continued to work until then.

Medical Examination

Unless you have qualified for SSDI Benefits, the PSRSSTL Medical Board must certify (1) that you are mentally or physically disabled from performing your job, (2) that your disability is likely to be permanent, and (3) that you should be retired. If the Medical Board is not able to make a determination regarding your disability from written reports, you may be asked to undergo a hands-on physical examination. The opinion of the Medical Board will be final and conclusive.

Ongoing Re-certification

You will be required to re-certify your disability status and demonstrate that you satisfy certain limitations on your earnings annually for the first five years of your disability pension and every three years thereafter until such time as you would have become eligible for Normal Pension had you continued to work. This re-certification process will include submitting a Physician's Statement and verification of your income. Copies of your income tax returns and supporting documentation such as W2 and 1099 Forms will be required.

DISABILITY PENSION APPLICATION

PUBLIC SCHOOL RETIREMENT SYSTEM OF THE CITY OF ST. LOUIS (PSRSSTL)
3641 Olive Street, Suite 300, ST. LOUIS, MO 63101-1657
TELEPHONE: (314) 534-7444

Please type or print in ink. You MUST sign and date Sections 2, 3, 4 and 5. PSRSSTL must receive this application AT LEAST 15 days prior to your Pension Effective Date. Late receipt of this Pension Application will cause your Pension Effective Date to be delayed. To obtain a quote under Benefit Payment Option 5, 6 or 7, you must provide an estimate from Social Security of your benefit amount at age 62. The beneficiary designations you make on this Pension Application will replace any designations on file with PSRSSTL effective on your Pension Effective Date.

SECTION 1. PERSONAL INFORMATION

YOUR NAME _____ SEX ☐ MALE ☐ FEMALE

STREET ADDRESS _____ MARITAL STATUS _____

CITY/STATE/ZIP _____ BIRTH DATE _____

SOC. SEC. NO. _____ PERSONNEL NUMBER _____ AGE AT RETIREMENT _____

JOB TITLE _____ WORK PHONE _____

EMPLOYMENT TYPE _____10 MONTH _____10.5 MONTH _____11 MONTH _____12 MONTH HOME PHONE _____

SECTION 2. APPLICATION FOR PENSION BENEFITS

If your application for disability is approved, your disability pension effective date will be the later of the first day of the month following fifteen days after the date your application was received by PSRSSTL or the first day of the month following the last day for which you received pay.

ENTER THE LAST DAY FOR WHICH YOU EXPECT TO BE PAID BY YOUR EMPLOYER *(include salary, sick leave, etc.)* _____

X _____ X _____

Your Signature ***Date of Signature***

SECTION 3. BENEFIT PAYMENT OPTIONS

☐ **I DO NOT ELECT A BENEFIT PAYMENT OPTION.** IF YOU CHECK THIS BOX, YOU MUST SIGN AND DATE BELOW AND INITIAL HERE. _____

☐ **I DO ELECT A BENEFIT PAYMENT OPTION.** I UNDERSTAND THAT IF I ELECT TO RECEIVE MY PENSION BENEFITS UNDER ONE OF THE SURVIVOR PAYMENT OPTIONS DESCRIBED BELOW, MY BENEFITS WILL BE REDUCED IN ORDER TO PROVIDE MONTHLY PAYMENTS TO MY OPTION BENEFICIARY AFTER MY DEATH. I UNDERSTAND THAT I MAY NOT CHANGE MY PAYMENT OPTION OR MY OPTION BENEFICIARY AFTER MY PENSION BENEFIT PAYMENTS BEGIN. I ALSO UNDERSTAND THAT IF I SELECT ONE OF THE SURVIVOR PAYMENT OPTIONS BELOW, I MUST PROVIDE PSRSSTL WITH A COPY OF THE BIRTH CERTIFICATE AND SOCIAL SECURITY CARD OF MY OPTION BENEFICIARY AT LEAST 15 DAYS PRIOR TO MY PENSION EFFECTIVE DATE.

(Place a check mark in the appropriate box to indicate the Payment Option you are electing. Provide Option Beneficiary information and sign and date below.)

☐ **Option 1** If the Option Beneficiary I have designated below is still living at the time of my death, my reduced monthly benefit payments shall continue to my Option Beneficiary on a monthly basis for his/her lifetime.

☐ **Option 2** If the Option Beneficiary I have designated below is still living at the time of my death, half of the amount of my reduced monthly benefit payments shall continue to my Option Beneficiary on a monthly basis for his/her lifetime.

☐ **Option 3** The same as Option 1, except that, if my Option Beneficiary dies before I do, effective the first day of the month following my Option Beneficiary's death, my reduced monthly benefit will be increased to the amount I would have received at the time of my retirement had I not elected this Benefit Payment Option.

☐ **Option 4** The same as Option 2, except that, if my Option Beneficiary dies before I do, effective the first day of the month following my Option Beneficiary's death, my reduced monthly benefit will be increased to the amount I would have received at the time of my retirement had I not elected this Benefit Payment Option.

☐ **Option 5** My monthly benefit prior to age 62 shall be increased so that my pension prior to age 62 shall be approximately equal to the sum of my pension after age 62 plus my estimated federal Social Security benefit.

☐ **Option 6** My monthly benefit shall be a combination of Benefit Payment Option 1 and Benefit Payment Option 5.

☐ **Option 7** My monthly benefit shall be a combination of Benefit Payment Option 2 and Benefit Payment Option 5.

_____ _____

Name of Option Beneficiary ***Option Beneficiary's Social Security Number***

_____ _____

Relationship ***Option Beneficiary's Date of Birth***

_____

Option Beneficiary: Street Address, City, State, Zip Code

X _____ X _____

Your Signature ***Date of Signature***

Over, please

DIS.PEN.APPL.2004-12-01

OFFICE USE ONLY: ELIGIBILITY DETERMINED _____ VERIFIED _____ TO INS. DEPT. _____

SECTION 4. BENEFICIARY DESIGNATION

COMPLETE THIS SECTION 4 EVEN IF YOU NAMED AN OPTION BENEFICIARY IN SECTION 3. IF YOU ELECTED A SURVIVOR BENEFIT PAYMENT OPTION AND NAMED AN OPTION BENEFICIARY IN SECTION 3, YOU SHOULD DESIGNATE A DIFFERENT BENEFICIARY(IES) IN THIS SECTION 4.

If I die (or if my Option Beneficiary and I both die) before the sum total of pension benefits which have been paid equals or exceeds my contributions to PSRSSTL, plus accumulated interest thereon, the difference will be paid to the Primary Beneficiary(ies) named below; however, if my Primary Beneficiary(ies) is not living, the difference will be paid to the Contingent Beneficiary(ies) named below.

Primary Beneficiary(ies)

Name of Primary Beneficiary | *Relationship* | *Soc. Sec. No.* | *Date of Birth*

Street Address, City, State, Zip Code

Name of Primary Beneficiary | *Relationship* | *Soc. Sec. No.* | *Date of Birth*

Street Address, City, State, Zip Code

Contingent Beneficiary(ies)

Name of Contingent Beneficiary | *Relationship* | *Soc. Sec. No.* | *Date of Birth*

Street Address, City, State, Zip Code

Name of Contingent Beneficiary | *Relationship* | *Soc. Sec. No.* | *Date of Birth*

Street Address, City, State, Zip Code

X *Your Signature* **X** *Date of Signature*

SECTION 5. HEALTH CARE INSURANCE INFORMATION

INDICATE BELOW IF YOU WISH TO ENROLL FOR MEDICAL, DENTAL AND/OR VISION INSURANCE. YOU MAY ONLY ENROLL FOR PSRSSTL-SPONSORED INSURANCE (1) UPON YOUR RETIREMENT, (2) DURING THE OPEN ENROLLMENT PERIOD IMMEDIATELY FOLLOWING YOUR ELIGIBILITY FOR MEDICARE, OR (3) WITHIN THIRTY DAYS OF YOUR INVOLUNTARY LOSS OF OTHER GROUP COVERAGE.

Enrollment forms and benefit information about the insurance programs you indicate below will be mailed to you under separate cover. Complete the appropriate insurance enrollment forms and return them to PSRSSTL within ten days of filing your Pension Application. If you do not wish to enroll for insurance at the time of your retirement because you have other group coverage, complete and return a Waiver Form to PSRSSTL within ten days of filing your Pension Application.

Medical Insurance

I wish to enroll for medical insurance effective with my retirement. ❑ **Yes** ❑ **No**

As of your retirement date, will you or any of the dependents you wish to enroll for medical insurance be entitled to Medicare insurance benefits due to age or disability status with the Social Security Administration? If yes, contact PSRSSTL immediatley. Medicare-entitled members and dependents must have both Part A and Part B coverage to be eligible to enroll for PSRSSTL insurance. ❑ **Yes** ❑ **No**

Provide the name of the medical plan under which you are currently covered through St. Louis Public Schools.

Dental Insurance

I wish to enroll for dental insurance effective with my retirement. ❑ **Yes** ❑ **No**

Vision Insurance

I wish to enroll for vision insurance effective with my retirement. ❑ **Yes** ❑ **No**

X *Your Signature* **X** *Date of Signature*

PHYSICIAN REPORT OF DISABLING CONDITION

Public School Retirement System of the City of St. Louis (PSRSSTL)
3641 OLIVE STREET, SUITE 300 ST. LOUIS, MO 63108-3601
(314) 534-7444

Instructions: Except for required signatures, type or print in ink.
Member/patient should complete Sections I and II. Treating physician should complete Sections III and IV.
Return completed form to PSRSSTL at the address above.

SECTION I - MEMBER/PATIENT INFORMATION

NAME _____

STREET ADDRESS _____

CITY/STATE/ZIP _____

SOC. SEC. NO. _____ BIRTH DATE _____ AGE _____

JOB TITLE _____ DEPARTMENT _____

WORK PHONE _____ HOME PHONE _____

SECTION II - MEMBER/PATIENT AUTHORIZATION TO RELEASE INFORMATION/RECORDS

I HEREBY AUTHORIZE THE PHYSICIAN COMPLETING THIS FORM TO RELEASE ANY AND ALL INFORMATION ABOUT MY DISABLING CONDITION TO PSRSSTL FOR THE PURPOSE OF COMPLETING MY APPLICATION FOR DISABILITY PENSION.

_____ _____
Member/Patient Signature Date of Signature

SECTION III - PHYSICIAN'S REPORT OF PATIENT'S DISABLING CONDITION

1. History

A. When did symptoms first appear or accident happen? Mo _____ Day _____ Year _____

B. When did patient become unable to work due to condition? Mo _____ Day _____ Year _____

2. Diagnosis

A. Diagnosis (include any complications)

_____

_____

_____

B. Subjective Symptoms

_____

_____

_____

C. Objective Findings (include clinical findings and results of diagnostic tests)

_____

_____

_____

3. Dates of Treatment

A. Date you first saw patient for the disabling condition Mo _____ Day _____ Year _____

B. Date you began treating patient for the disabling condition Mo _____ Day _____ Year _____

C. Date you last saw patient for the disabling condition Mo _____ Day _____ Year _____

D. Frequency of treatment ☐ Weekly ☐ Monthly ☐ Other _____

Over, please

SECTION III - PHYSICIAN'S REPORT OF PATIENT'S DISABLING CONDITION (continued)

4. Progress

A. Patient ☐ Has Recovered ☐ Is Improving ☐ Is Unchanged ☐ Has Regressed

B. Patient is ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospitalized

C. Has patient been hospitalized? ☐ Yes ☐ No

If yes, confined *(enter dates)* from _____ through _____

5. Describe Nature of Treatment *(include surgery and medications prescribed)*

_____

_____

6. Cardiac Information *(if applicable)*

A. Describe functional capacity _____

B. Blood pressure at last visit _____

7. Physical Impairment *(as defined in the federal dictionary of occupational titles)*

☐ **Class 1 No Limitation**, capable of heavy work (0 - 10%)

☐ **Class 2 Medium Manual Activity** (15 - 30%)

☐ **Class 3 Slight Limitation**, capable of light work (35 - 55%)

☐ **Class 4 Moderate Limitation**, capable of sedentary activity (60 - 70%)

☐ **Class 5 Severe Limitation**, incapable of minimal activity (75 - 100%)

8. Mental/Nervous Impairment *(if applicable)*

☐ **No Limitations**, patient is able to function under stress and engage in interpersonal relations.

☐ **Slight Limitations**, patient is able to function under most stressful situations and may engage in limited interpersonal relations.

☐ **Moderate Limitations**, patient is able to engage in only limited stressful situations and interpersonal relations.

☐ **Marked Limitations**, patient is not able to engage in stressful situations or interpersonal relations.

☐ **Severe Limitations**, patient has significant loss of psychological, physiological, personal and social adjustment.

9. Prognosis *(Please answer these questions with respect to patient's current job. If a description of the patient's job duties will assist you in completing Question 9, contact PSRSSTL at (314) 241-7763.)*

A. Is patient now disabled from performing his/her job? ☐ Yes ☐ No

B. If not now disabled, when was patient able to resume work? (Please enter date) _____

C. If currently disabled, what duties of his/her job is the patient incapable of performing?

_____

_____

D. When will patient recover sufficiently to perform his/her job duties?

☐ 1 Month ☐ 1-3 Months ☐ 3-6 Months ☐ Probably Never

10. Comments/Remarks

_____

_____

SECTION IV - PHYSICIAN INFORMATION

Name of Physician (please print)	Telephone Number	Specialty or Degree

Street Address	City, State, Zip

Signature of Physician	Date of Signature

SECTION 6. MEMBER STATEMENT OF DISABLING CONDITION

Except for your signature, type or print in ink. Describe your disabling condition and how the condition affects your ability to perform your job. Provide adequate detail. If you need additional space, attach additional sheets. Return this Application with the Physician Report of Disabling Condition or a copy of your award letter for disability benefits from the Social Security Administration to the Public School Retirement System of the City of St. Louis.

A. Describe the nature of your disabling condition and when it began.

B. Describe your job duties and how your disabling condition affects your ability to perform your job.

C. Provide the following information for the primary physician who is treating you for the disabling condition.

Name of Physician

Telephone Number

Street Address of Physician

Specialty or Degree

City, State, Zip

I understand that my Aplication for Disability Pension will not be submitted to the Board of Trustees for approval until all required information, including a favorable Medical Board recommendation, has been received by PSRSSTL. I also understand that the Medical Board may need to perform a hands-on physical to render a recommedation.

X

Your Signature

X

Date of Signature

D. If applicable, list below additional physicians who are treating you for the disabling condition.

Name of Physician

Telephone Number

Street Address of Physician

Specialty or Degree

City, State, Zip

Name of Physician

Telephone Number

Street Address of Physician

Specialty or Degree

City, State, Zip