ERS
Employees Retirement System of Texas

200 E. 18th Street, Austin, Texas 78701 | P. O. Box 13207, Austin, Texas 78711-3207 | (877) 275-4377 Toll-free | www.ers.state.tx.us

Dear Member:

You have requested to apply for disability retirement. To be eligible, you must have been working for the state at the time you became disabled.

Enclosed are the forms we need completed to start this process. Please return all required information at the same time.

☐ **APPLICATION FOR DISABILITY RETIREMENT BENEFITS**
Carefully review and complete the form. Please return the original notarized form to us.

☐ **ATTENDING PHYSICIAN STATEMENT**
A medical doctor (Doctor of Medicine or Doctor of Osteopathic Medicine) must complete this form. Please return the original notarized form to us.

☐ **DEPARTMENTAL STATEMENT**
Your agency must complete this form. The agency must provide copies of all documentation indicated on the form. Please return the original notarized form to us.

☐ **MEDICAL RECORDS**
We require copies of medical and/or surgical records related to your injury/medical condition. Please include copies of the reports from imaging studies such as X-ray, MRI, etc.

You may be able to get one free copy of your medical records. For more information, please visit www.statutes.legis.state.tx.us and see Section 161.202 of the Texas Health and Safety Code. ERS is unable to give you legal advice.

We must receive all forms by your requested retirement date. Please submit all original forms by mail at the same time. Notarized forms may not be faxed. We will review your disability retirement application and notify you if we need additional information or confirm we have received all required forms.

Sincerely,

Customer Benefits

ERS
EMPLOYEES RETIREMENT SYSTEM OF TEXAS

APPLICATION FOR DISABILITY RETIREMENT BENEFITS

Please mail this completed form to:
Employees Retirement System of Texas
Customer Benefits
PO BOX 13207, Austin, TX 78711-3207
877-275-4377 Toll-free

Information provided to Employees Retirement System of Texas (ERS) is maintained for administration of your benefits. If you have questions about your information, or believe that information provided to ERS may be incorrect, please notify ERS.

Disability Retirement Information and Instructions

- The retirement date must be in the future—it cannot be a past date.
- You must have been an active, contributing member of ERS at the time you became disabled.
- You cannot apply more than 90 days in advance of your requested retirement date.
- You cannot be working or on a leave status, including paid or unpaid leave, the day after your requested retirement date.
- Your retirement date must be the last day of the month.
- All documents must be received by ERS before we can review your disability retirement application.
- After you submit your application, you must immediately report any change in your work status to ERS.
- You must answer all questions and provide detailed answers as applicable.
- If approved, health insurance benefits may be subject to a 60 day waiting period.
- If you make a mistake, put your initials next to any corrections. Please do not use white-out.
- We do not accept incomplete, illegible forms, or copies of forms necessary for your application.
- You must sign this application in front of a notary public and mail the original, notarized form to ERS at the address shown above.
- You must provide copies of all medical or surgical records related to your injury/medical condition, including copies of the reports from imaging studies, such as MRIs, x-rays, etc.

MEMBER INFORMATION

Employee Name: First, MI, Last	Phone Number		
	Home ( )	Cell ( )	
Mailing Address	**City**	**State**	**Zip Code**
Employing Agency	**Last 4 Digits of SSN**	**Your Requested Retirement Date**	
	XXX-XX-		

CAREFULLY READ THE QUALIFICATIONS FOR DISABILITY RETIREMENT

NONOCCUPATIONAL DISABILITY REQUIREMENTS

- You must be mentally or physically incapacitated for the further performance of duty, meaning you have sought and been denied workplace accommodation of the disability and you are unable to hold the position occupied, and you are unable to hold any other job offering comparable pay.
- Your application must be submitted within two years of the date of your last ERS retirement contribution.
- You must have at least 10 years of creditable state service credit.
- You may purchase withdrawn service and military service to meet the 10 year requirement.
- You may use service with the Teacher Retirement System of Texas to meet the 10 year requirement.
- You cannot use proportionate service credit and Optional Retirement Program service to meet the 10 year requirement.
- Your incapacity must likely be permanent.

OCCUPATIONAL DISABILITY REQUIREMENTS

- You must be mentally or physically incapacitated for the further performance of duty, meaning you have sought and been denied workplace accommodation of the disability and you are unable to hold the position occupied, and you are unable to hold any other job offering comparable pay.
- Your application must be submitted to ERS no later than two years after your disabling condition, unless good cause exists for filing the claim at a later time.
- Your incapacity must have directly resulted from a sudden and unexpected injury or disease that resulted solely from a specific act or occurrence determinable by a definite time and place and solely from an extremely dangerous risk or severe physical or mental trauma or disease that was not common to the public at large and that was peculiar to and inherent in a dangerous duty that arose from the nature and in the course of your state employment.
- Your incapacity must most likely be permanent.

MEMBER INFORMATION

1. Based on the requirements listed above, are you applying for nonoccupational or occupational disability retirement?

You must select only one option.

☐ **Nonoccupational** ☐ **Occupational**

If occupational, list the date of your injury _____ (mm/dd/yyyy)

2. Describe your symptoms and limitations caused by your disabling medical condition.
You may attach an extra sheet or more of paper if you need additional space.

3. List all your diagnosed disease(s) and/or injury(s) that contribute to your incapacity. Include the date of onset, the cause, the date of your first and last examination/treatment for your condition, and the attending physician(s) contact information.

Diagnosis	Date Condition Began	Cause	
Date of First Exam		Date of Last Exam	
Attending Physician(s):		Primary Specialty(s):	
Mailing Address:	City	State	Zip Code

Diagnosis	Date Condition Began	Cause	
Date of First Exam		Date of Last Exam	
Attending Physician(s):		Primary Specialty(s):	
Mailing Address:	City	State	Zip Code

Diagnosis	Date Condition Began	Cause	
Date of First Exam		Date of Last Exam	
Attending Physician(s):		Primary Specialty(s):	
Mailing Address:	City	State	Zip Code

4. If you are applying for occupational disability retirement, have you ever had the same, similar, or related disease(s) or injury(s) at any time in the past?

☐ Yes ☐ No If yes, please provide the following details:

Disease/Injury	Date	Explanation

5. If you are applying for occupational disability retirement, provide the following details if your incapacity was caused by an accident:

Date of Accident:	Location of Accident:
Give specific information on how the accident occurred:	

____

6. If you applying for occupational disability retirement, has any other disease(s) or injury(s) aggravated your condition?

☐ **Yes** ☐ **No** **If yes, please provide the following details:**

Disease/Injury	Date	Explanation

7. Over the last six months, do you believe your condition has:

Please Check ☐ **Improved** ☐ **Declined** ☐ **Stayed the Same**

Explanation

8. Does your condition make you unable to perform the duties of your state job even with a reasonable accommodation?

☐ **Yes** ☐ **No** **Please explain:**

9. Did you seek workplace accommodations that would have enabled you to continue your state employment?

☐ **Yes** ☐ **No** **Please explain:**

10. If you answered yes to the previous question, were the accommodations denied?

☐ **Yes** ☐ **No** **Please explain:**

11. Does your condition make you unable to perform the duties of any job?

☐ **Yes** ☐ **No**

What other jobs could you do?

☐ **Yes** ☐ **No** **Please explain:**

12. Does your condition make you unable to work on a part-time basis?

☐ **Yes** ☐ **No**

What part-time jobs could you do?

☐ **Yes** ☐ **No** **Please explain:**

SURGICAL INFORMATION

13. Have you had any surgical procedures that are directly related to any diagnosis you identified in your response to Question 3?

☐ Yes ☐ No If yes, please complete the following:

Date	Procedure	Surgeon
Hospital/clinic:	**Referring physician, if applicable:**	

Date	Procedure	Surgeon
Hospital/clinic:	**Referring physician, if applicable:**	

Date	Procedure	Surgeon
Hospital/clinic:	**Referring physician, if applicable:**	

14. Do you intend to have any surgical procedures that are directly related to your diagnosis identified in response to Question 2?

☐ Yes ☐ No If yes, please complete the following:

Date	Procedure	Surgeon
Hospital/clinic:	**Referring physician, if applicable:**	

Date	Procedure	Surgeon
Hospital/clinic:	**Referring physician, if applicable:**	

EMPLOYMENT INFORMATION

15. Has a benefit been filed on your behalf with Worker's Compensation (State Office of Risk Management)?

☐ **Yes** ☐ **No**

If no, do you plan to file for Worker's Compensation?

☐ **Yes** ☐ **No**

16. Are you still working at your state job?

☐ **Yes** ☐ **No**

17. Are you currently on any type of leave status, such as sick leave, extended sick leave, FMLA, or vacation?

☐ **Yes** ☐ **No**

If you answered yes, what type of leave are you currently on? _____

What was the date you went on leave? _____ (mm/dd/yyyy)

18. What was the last day you were physically present at work prior to termination because of your disability?

_____ (mm/dd/yyyy)

19. Have you applied or do you plan to apply for unemployment compensation?

☐ **Yes** ☐ **No** **Please explain:**

_____
_____
_____
_____

20. Have you attempted to find other employment since leaving State employment?

☐ **Yes** ☐ **No** **If yes, please provide the following:**

Name of Employer	Position Sought	Monthly Salary

21. Are you currently working in any capacity?

☐ **Yes** ☐ **No** **If yes, please provide the following:**

Name of Employer	Position	Monthly Salary

EDUCATION INFORMATION

Type of School	Name of School	Type of Diploma/Degree	Major/Minor Field of Study
Undergraduate Colleges or Universities			
Graduate Schools			
Technical, Vocational, or Business Schools			

Vocational License/ Certification	Date Issued	Date Expires	Issued By	License Number

Special Training/Skills

EMPLOYMENT HISTORY - You may add additional pages if necessary.

Most Current Employer			
Employer Name:		**Dates of Employment:**	
Current Salary:		**Immediate Supervisor's Name:**	

Description of Job Duties:

Previous Employer			
Employer Name:		**Dates of Employment:**	
Ending Salary:		**Immediate Supervisor's Name:**	

Description of Job Duties:

Previous Employer			
Employer Name:		**Dates of Employment:**	
Ending Salary:		**Immediate Supervisor's Name:**	

Description of Job Duties:

YOU MUST SIGN THIS FORM IN FRONT OF A NOTARY PUBLIC AND MAIL THE ORIGINAL, NOTARIZED FORM TO ERS.

CERTIFICATION STATEMENT

- I am incapacitated from further performance of any job duty.
- I understand that my disabling condition is likely to be permanent.
- I understand that my application will be cancelled if I am working or if I am on any paid or unpaid leave status following my selected retirement date.
- I authorize the release of all information, including, but not limited to medical records and departmental reports, from all sources, individuals, or governmental agencies to Employees Retirement System of Texas (ERS) in order to determine my rights to disability retirement benefits and for other official use as the agency deems necessary.
- I hereby certify that I am in compliance with §73.17 of the Texas Administrative Code which requires that I have demonstrably sought and been denied workplace accommodation of my disability and that I am physically or mentally unable to continue to hold the position occupied and to hold any other position offering comparable pay. I also understand that my education, training, and experience are considered when making this demonstration.
- I understand that if my application is approved, my eligibility for disability retirement may be reevaluated and I may be required to undergo medical examinations, and provide additional information satisfactory to ERS that is relevant to determining whether I remain eligible. My failure to submit to a medical examination, and/or to provide the information requested, may result in a suspension of my disability retirement and associated insurance benefits until I comply. My failure to comply with the requirements for more than one year may result in termination of the benefits.
- I hereby certify, under the penalties of perjury, that the above statements and answers were made by me based on personal knowledge, and that my statements and answers are each and all complete and true to the best of my knowledge, information, and belief.

_____ _____

Applicant Signature Date

NOTARY PUBLIC CERTIFICATION

State of _____ County of _____

This instrument was acknowledged before me on this _____ day _____ month _____ year

by _____ (Member printed name)

Notary Public Signature _____

(SEAL/STAMP)

My commission expires: _____ (per Tx Gov't Code 121.008)

ERS
Employees Retirement System of Texas

ATTENDING PHYSICIAN STATEMENT FOR DISABILITY RETIREMENT APPLICATION

Please mail this completed form to:

Employees Retirement System of Texas
Customer Benefits
PO Box 13207
Austin Texas 78711-3207

(877) 275-4377 Toll-free

Information provided to the Employees Retirement System of Texas (ERS) is maintained for administration of your benefits. If you have questions about your information, or believe that information provided to ERS may be incorrect, please notify ERS.

INSTRUCTIONS

- Only a Medical Doctor or Doctor of Osteopathic Medicine is authorized to complete this statement.
- Answer all questions thoroughly providing objective medical information.
- Please include copies of the patient's history (including chief complaint), progress notes, all ancillary testing reports, and any other pertinent information.
- If corrections need to be made, please initial beside the correction.
- **We do not accept incomplete and/or illegible forms**. Please use "N/A" if a question does not apply.
- The medical doctor (Doctor of Medicine or Doctor of Osteopathic Medicine) signature MUST be witnessed by a Notary Public.

IMPORTANT INFORMATION

The patient is responsible for charges associated with the completion of this form, including medical records or copies.

PATIENT INFORMATION

Name of Patient	Last 4 Digits of SSN
	XXX-XX-

Medical Doctor (Doctor of Medicine or Doctor of Osteopathic Medicine)	Clinic Affiliation

Street Address	City	State	ZIP Code	Phone Number

Medical School	Graduation Date
Primary Specialty	**Certification Date**

PATIENT HISTORY

1. Are you the Primary Care Physician for this patient? ☐ **YES** ☐ **NO** If no, indicate the type of care you provide for this patient below:

____

____

____

2. Are you still treating this patient? ☐ **YES** ☐ **NO** Please provide frequency of examinations:

	Weekly		Bi-weekly		Monthly		Bi-monthly
	Quarterly		Semi-Annually		Annually		As needed

3. List all diagnosed diseases and/or injuries. Please be sure to indicate if known with reasonable medical probability the date of onset, the cause, and the date the patient was first examined and last examined.
WE DO NOT ACCEPT CODES (ICD-9).

Diagnosis (NO CODES)	Date of Diagnosis*	Cause	
Date of First Exam:		Date of Last Exam:	
Diagnosis (NO CODES)	Date of Diagnosis*	Cause	
Date of First Exam:		Date of Last Exam:	
Diagnosis (NO CODES)	Date of Diagnosis*	Cause	
Date of First Exam:		Date of Last Exam:	
Diagnosis (NO CODES)	Date of Diagnosis*	Cause	
Date of First Exam:		Date of Last Exam:	
Diagnosis (NO CODES)	Date of Diagnosis*	Cause	
Date of First Exam:		Date of Last Exam:	

*If known with reasonable medical probability

4. Has the patient ever had at any time in the past the same, similar, or related disease or injury with respect to the condition(s)? ☐ **YES** ☐ **NO** If yes, please indicate the disease/injury, the date and explain:

Disease/Injury	Date	Explain

5. Has any other disease or injury aggravated the patient's condition?
☐ **YES** ☐ **NO** If yes, please indicate the disease/injury, the date and explain:

Disease/Injury	Date	Explain

6. Please give the following findings in regard to your last examination of the patient.

Height	Weight	Blood Pressure
____ feet____ inches	_____ pounds	systolic ____ mm diastolic ____ mm

7. Over the last six months, has the patient's condition:

Please Check		Explain
	Improved	
	Retrogressed	
	Stabilized	

8. Please check all limits on activities/functions and exposure to environmental factors you have placed on the patient because of the disease or disabling injury as diagnosed and indicate the limit. We will assume the patient, without any reasonable accommodation, can be exposed to or perform any item not checked.

Please Check	Activity/Function	Limits
	Climbing stairs	Maximum # of stairs _____
	Lifting/Carrying	Weight maximum _____lbs.
	Walking	Distance maximum _____miles
	Driving	Distance maximum _____miles
	Running	Distance maximum _____miles
	Crawling	Distance maximum _____miles
	Sitting	Time maximum _____minutes
	Typing	Time maximum _____minutes
	Writing	Time maximum _____minutes
	Bending/Stooping	Time maximum _____minutes
	Kneeling/Squatting	Time maximum _____minutes
	Twisting	Time maximum _____minutes
	Grasping/Squeezing	Time maximum _____minutes
	Pulling/Pushing	Time maximum _____minutes
	Operate motor equipment	Time maximum _____minutes
	Repetitive movement	Time maximum _____minutes
	Hearing	
	Speaking	
	Follow policy and procedure	
	Respond to Emergencies	
	Cognitive Functions	
	Memory	

Please Check	Environmental Factor	Explain
	Fumes	
	Humidity	
	Dust	
	Chemicals	
	Temperature extremes	Min. temp. _____ Max. temp. _____
	Noise	
	Vibration	
	Heights	Height maximum _____feet

9. Indicate any additional findings from the patient's last examination and explain the findings' relevance as related to the patient's disability claim(s).

Additional Finding	Explain

10. Is the condition of the patient likely to be permanently incapacitating with respect to the patient's state employment?

☐ **YES** ☐ **NO** Please explain:

_____
_____
_____
_____

11. Is the condition of the patient likely to be permanently incapacitating with respect to any other occupation(s)?

☐ **YES** ☐ **NO** Please describe employment capabilities:

_____
_____
_____
_____

12. Is your opinion regarding the patient's capacity to work based solely on the patient's opinions regarding disability?

☐ **YES** ☐ **NO** Please explain:

_____
_____
_____
_____

13. Has the patient been referred for further evaluation? ☐ **YES** ☐ **NO** If yes, please indicate below:

Physician	Primary Specialty	Physician	Primary Specialty

SURGICAL INFORMATION

14. Has the patient had any surgical procedures that are directly related to your diagnosis on page 2?

☐ **YES** ☐ **NO** If yes, please indicate below:

Date	Procedure	Explain

PRESCRIPTION INFORMATION

15. Do you prescribe medication for the patient? ☐ **YES** ☐ **NO** If yes, list them below:

Medication	Dosage	Frequency

ADDITIONAL COMMENTS:

_____

_____

_____

_____

_____

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.

_____ _____

Signature of Attending Physician Date Signed

NOTARY PUBLIC CERTIFICATION

State of _____ County of _____

This instrument was acknowledged, sworn to, and subscribed before me on the

_____ day of _____, _____ by _____

Month Year Name of Physician

_____

Notary Public Signature

Seal/Stamp

ERS
Employees Retirement System of Texas

DEPARTMENTAL STATEMENT FOR DISABILITY RETIREMENT APPLICATION

Please mail this completed form to:

Employees Retirement System of Texas
Customer Benefits
PO Box 13207
Austin Texas 78711-3207

(877) 275-4377 Toll-free

Information provided to the Employees Retirement System of Texas (ERS) is maintained for administration of member benefits. If members have questions about their information, or believe that information provided to ERS may be incorrect, they should notify ERS.

INSTRUCTIONS

- This form may only be completed by an agency human resources official.
- We do not accept copies, incomplete, or illegible forms. Please answer "N/A" if a question does not apply.
- This form must be signed by an agency official in front of a notary public.
- Mail the original, notarized form to ERS.
- Include a copy of the member's State of Texas employment application with a copy of his or her current job description.

REQUIRED DOCUMENTATION

- Employment application
- Official job description
- Medical Records on file and any other health related information.
- Educational background
- Training background

FOR OCCUPATIONAL APPLICATIONS INCLUDE

- All injury reports
- All witness statements

EMPLOYEE INFORMATION

Name of Member	Last 3 Digits of SSN	Requested Retirement Date
	XXX-XX-X	

Disability Retirement Application Type: Please select one option	☐ **Occupational** ☐ **Nonoccupational**

POSITION INFORMATION: PLEASE INCLUDE A COPY OF THE OFFICIAL JOB DESCRIPTION

Agency Name	
Working Title	
Classification Title	

REQUIRED REASONABLE ACCOMMODATION INFORMATION

TEXAS GOVERNMENT CODE §814.203 (b) Incapacity from the further performance of duty means that the member has demonstrably sought and been denied workplace accommodation of the disability in accordance with applicable law, and that the member is physically or mentally unable to continue to hold the position occupied and to hold any other position offering comparable pay. The education, training, and experience of the employee are to be considered when making this determination.

1. **Did the employee request reasonable accommodations that would allow him/her to continue in the last position held?**
   ☐ **Yes** ☐ **No** **Please explain**

If No, did the employer offer reasonable accommodations?
☐ **Yes** ☐ **No** **Please explain**

2. **If you answered yes to the previous question, was the employee approved for reasonable accommodations?**
   ☐ **Yes** ☐ **No** **Please explain**

3. **If so, was the employee able to fulfill all of the essential job functions after being accommodated?**
   ☐ **Yes** ☐ **No** **Please explain**

4. **Can any existing positions offering comparable pay be modified to accommodate the employee?**
   ☐ **Yes** ☐ **No** **Please explain**

5. **If so, has any position of comparable pay been offered to the employee?**
   ☐ **Yes** ☐ **No** **Please explain**

OCCUPATIONAL INJURY INFORMATION

814.201. Information About Occupational Disability (a) A member who applies for retirement for an occupational disability shall furnish the retirement system all information and other data requested by the retirement system and relating to the disability. (b) The retirement system may require information and other data relating to an occupational disability retirement application to be furnished by any officer or employee of the agency with which the applicant holds a position.

PLEASE PROVIDE A COPY OF ALL MEDICAL AND INJURY REPORTS ON FILE

Injury	Date	Brief description of injury

6. **Was the employee performing the normal duties of his/her position when the injury occurred?**
   ☐ **Yes** ☐ **No** **Please explain**

7. **Did the employee ever have at any time in the past the same, similar, or related injury with respect to the condition identified by the employee as causing his/her disability?**
   ☐ **Yes** ☐ **No** **Please explain**

EMPLOYMENT INFORMATION

8. **Is the employee still physically at work?**
   ☐ **Yes** ☐ **No**
   If you answered No, what was the last day the employee was physically present at work?
   _____ (mm/dd/yyyy)

9. **Is the employee on any type of leave status such as sick leave, extended sick leave, FMLA, or vacation?**
   ☐ **Yes** ☐ **No**
   If you answered yes, what type of leave is the employee currently on? _____
   What was the date the employee went on leave? _____

10. **If the employee is on any type of leave status, is he/she expected to return to work?**
    ☐ **Yes** ☐ **No**
    If you answered yes, what date is the employee expected to return to work?
    _____ (mm/dd/yyyy)

11. **Was the employee terminated from employment?**
    ☐ **Yes** ☐ **No**

12. **What is/was the employee's termination date?** _____ (mm/dd/yyyy)

13. **Is the employee's inability to work (if any) based on documented medical findings?**
    ☐ **Yes** ☐ **No**
    If yes, please explain and include the documentation obtained.

14. **What is/was the employee's final gross monthly salary?** _____

15. **Has the employee filed for unemployment benefits?**
    ☐ **Yes** ☐ **No**
    If so, please state the date of the application and whether benefits were granted.

• YOU MUST SIGN THIS FORM IN FRONT OF A NOTARY PUBLIC AND MAIL THE ORIGINAL, NOTARIZED FORM TO ERS.

• INCLUDE A COPY OF THE EMPLOYEE'S STATE OF TEXAS EMPLOYMENT APPLICATION AND POSITION DESCRIPTION.

DEPARTMENT OFFICIAL

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.

_____

Printed Name of Department Official

_____

Signature of Department Official

_____

Title

_____

Phone number Email Address

_____

Date signed

NOTARY PUBLIC CERTIFICATION

State of _____ County of _____

This instrument was acknowledged before me on this _____ day _____ month _____ year

by _____ (Departmental official)

Notary Public Signature _____

(SEAL/STAMP)

My commission expires: _____ (per Tx Gov't Code 121.008)