

APPLICATION FOR DISABILITY RETIREMENT
Completed by Employee

PRINT Employee/Member's Name		SSN	
Address		Date of Birth	
City, State and Zip Code		Email	
Home #	Cell #	Work #	

Employer _____ Service Date from _____ to _____

Break(s) in Service from _____ to _____ Break(s) in Service from _____ to _____

Type of Disability (check ONE): Accidental Total and Permanent Ordinary

Date of Disabling Event or Condition Diagnosis _____

Nature and Cause of Disability _____

List the doctors, hospitals and clinics who attended or examined your disability and three years prior
 (For additional doctors, attach a supplemental page)

Company Name	Company Name	Company Name
Doctor	Doctor	Doctor
Address	Address	Address
City, State, Zip+4	City, State, Zip+4	City, State, Zip+4
Phone	Phone	Phone
Illness	Illness	Illness

(For additional children, attach a supplemental page)

SPOUSE/CHILDREN: (Check box)				Print Name: (Last, First, Middle)	Date of Birth	Social Security Number	Disabled Child(ren)? Yes or No	Child(ren) 18-22 yrs in school fulltime? Yes or No
<input type="checkbox"/>	Spouse	<input type="checkbox"/>	Not applicable					
<input type="checkbox"/>	Child	<input type="checkbox"/>	Not applicable					
<input type="checkbox"/>	Child							
<input type="checkbox"/>	Child							

APPLICATION FOR DISABILITY RETIREMENT
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REQUIRED AUTHORIZATIONS AND UNDERSTANDING – Initial the following:

_____ I authorize and request each physician and person in the medical or related fields, and each hospital, clinic, establishment and place rendering or having in the past rendered to me any medical or related service to allow the Local Board, the office of the Board of Trustees of the Corrections Officer Retirement Plan (CORP), their authorized designee, and/or each physician appointed by them to have, examine and/or copy, any and all information, records, reports and x-rays, regarding my physical and/or mental condition and treatment therefore.

_____ I authorize the Local Board, the office of the Board of Trustees and/or their authorized designee to procure from my employer(s) or from any other person, firm or corporation (including any governmental agency or department thereof) any and all information as directly related to leave(s) of absence without pay and/or application(s) for and/or receipt of Worker's Compensation Benefits. I expressly waive all provision of law forbidding any doctor, person, firm or corporation (including any governmental agency or department thereof) from disclosing any knowledge or information which they have in their possession concerning leave(s) of absence without pay and/or Worker's Compensation.

_____ I understand that pursuant to A.R.S. § 38-893(H), the Board of Trustees may perform a review of the disability retirements to ensure that the employee/member and the Local Board are in compliance with statutory requirements.

Authorizations are in effect from the date of this application to 120 days after first receipt of retirement benefits.

WAIVER OF CONFIDENTIALITY

_____ I hereby consent, upon the advice of counsel, that all matters and issues relating to my physical or mental condition or medical history, including, without limitation, whether my physical or mental condition arises from any preexisting disability, may be discussed and considered by the Board of Trustees and/or Local Board in open public meeting, and I hereby waive any right to have my physical or mental condition or medical history discussed and evaluated by the Board of Trustees and/or Local Board in executive session only. As part of the aforesaid waiver, I further consent that the Board of Trustees and/or Local Board may discuss and consider all evidence touching upon my physical or mental condition or medical history in open public session, including without limitation, testimony or records concerning my physical or mental condition or medical history from physicians or other expert witnesses, the social security administration, the state industrial commission, or other sources or persons of any kind or description. I understand that neither the Board of Trustees nor the Local Board has any obligation to keep confidential any information about my physical or mental condition or medical history that is discussed, presented or considered during any public session of the Board of Trustees or Local Board, and I absolve the Board of Trustees and Local Board from any liability arising from disclosure of such information during public session.

I hereby submit my application for a disability pension subject to all of the terms and conditions of the CORP. I attest that all information submitted is true, complete and correct to the best of my knowledge and belief. I understand that A.R.S. § 38-912(C) states: "A person who knowingly makes any false statement or who falsifies or permits to be falsified any record of the system with an intent to defraud the system is guilty of a class 5 felony."

_____/_____/_____
Date Employee/Member's Signature Local Board Representative Signature

REQUIRED DOCUMENTATION (as applicable, provide your Local Board with a copy):

- 1. Birth Certificate
- 2. Marriage Certificate
- 3. Spouse's Birth Certificate
- 4. Dependent Child(ren) Birth Certificates
- 5. If divorced during period of employment:
 - a. Photocopy of complete Divorce Decree, or
 - b. Certified copy of Plan-approved Domestic Relations Order
- 6. Medical documentation for disabled children.

Received Stamp or PRINT Name and Signature of Local Board Representative Date

LOCAL BOARD DETERMINATION FOR DISABILITY RETIREMENT
Completed by Local Board

PRINT Employee/Member's Name _____

SSN _____

LOCAL BOARD INSTRUCTIONS - Based on the "Type of Disability" selected by the employee on FORM C5-EE, complete the applicable *DISABILITY QUESTIONNAIRE* (i.e., FORM C5-LB-A, FORM C5-LB-TP, or C5-LB-O).

Employer _____

Termination Date _____ / _____ / _____ Last Day on Payroll _____ / _____ / _____

Service Date from _____ / _____ / _____ to _____ / _____ / _____

Service Break(s) from _____ / _____ / _____ to _____ / _____ / _____

Service Break(s) from _____ / _____ / _____ to _____ / _____ / _____

Work Status (Select all that apply) Working Full-time Working Part-time Not Working Regular Assignment Limited Duty Paid Leave Unpaid Leave Other _____

DETERMINATION - Pursuant to A.R.S. § 38-893, the attached *DISABILITY QUESTIONNAIRE* and Medical Examination (if applicable), the Local Board has determined that the employee/member:

- Does not qualify for a disability retirement.
- Qualifies for an ACCIDENTAL DISABILITY retirement pension effective _____ / _____ / _____
- Qualifies for a TOTAL AND PERMANENT retirement pension effective _____ / _____ / _____
- Qualifies for an ORDINARY DISABILITY retirement pension effective _____ / _____ / _____

PRINT Name of Local Board Secretary or Chairman _____

Signature _____

Board Meeting Motion Date _____

Pursuant to § 38-893(H), the Board of Trustees may perform a review of the disability retirements to ensure that the Employee/Member and the Local Board is in compliance with statutory requirements.

LOCAL BOARD: Return **ORIGINALS** of this (C5-LB) form, C5-EE, *DISABILITY QUESTIONNAIRE* and provide the Medical Examination (if applicable), Local Board meeting minutes and "REQUIRED DOCUMENTS" as indicated on FORM C5-EE.

**ACCIDENTAL
 DISABILITY QUESTIONNAIRE**

Completed by Local Board and Doctor (if applicable)

Pursuant to A.R.S. §§ 38-881(1) and 38-886, an "Accidental disability" means a physical or mental condition that the local board finds totally and permanently prevents an employee from performing a reasonable range of duties within the employee's department, was incurred in the performance of the employee's duties and was a result of physical contact with inmates, prisoners, parolees or persons on probation, responding to a confrontational situation with inmates, prisoners, parolees or persons on probation, or a job-related motor vehicle accident while on official business for the employee's employer.		LOCAL BOARD Initial Response	
1. Did the employee file the application after the disabling incident or within one year of ceasing to be an employee?		YES	NO
2. Is the employee still working in a job the board believes is a reasonable range of duties?		YES	NO
3. Does the employer have any jobs available for the employee the board believes is a reasonable range of duties position? (Submit job descriptions and duties to the doctor if sent for IME.)		YES	NO
4. Did the employer terminate the employee's employment based on a physical or mental condition?		YES	NO
5. Did the employer terminate the employee's employment based on a disciplinary issue?		YES	NO
6. Did the member terminate employment based on a physical or mental condition?		YES	NO
7. Did the member terminate employment based on election to participate in Reverse DROP?		YES	NO
8. Has the member refused a job the board believes is a reasonable range of duties?		YES	NO
9. Was the injury the result of an event incurred during the performance of the member's duty detailed above?		YES	NO
LOCAL BOARD INSTRUCTIONS: If it is determined that the employee does not qualify, complete FORM C5-LB and forward to CORP. If evidence exists that the employee may qualify and no reasonable range of duty jobs are available, a medical examination (IME) will need to be performed. Sign/date this questionnaire and forward the ORIGINAL (along with the all medical evidence and any additional questions) to the doctor.			
DOCTOR INSTRUCTIONS: In addition to the IME report, answer the following questions, sign/date and return the ORIGINAL to the Local Board. Provide additional comments in the IME report.		DOCTOR Initial Response	
1. Does the member have the physical condition that is the basis for the disability application?		YES	NO
2. Does the member have the mental condition that is the basis for the disability application?		YES	NO
3. Did the condition permanently prevent the member from performing a reasonable range of duties within the employee's department?		YES	NO
4. Did the condition totally prevent the member from performing a reasonable range of duties within the employee's department?		YES	NO
5. Did your review include a medical report describing any conditions or injuries that existed prior to membership in the pension system? If yes, address in IME report.		YES	NO
6. Did your review find any pre-existing conditions or injuries that played a role in the disability claimed by the member? If yes, address in IME report.		YES	NO
7. Was the injury a result of an event incurred during the performance of the member's duty detailed above?		YES	NO
8. Are there conflicts in the medical evidence? If yes, address in IME report.		YES	NO
LOCAL BOARD: If conflicts in the medical evidence, address if and how they were resolved in the Local Board meeting minutes. LOCAL BOARD AND DOCTOR: By my signature below, I attest that the medical records have been thoroughly reviewed, each section/questions have been answered by the appropriate party indicated above, and the information contained herein is true, complete and correct to the best of my knowledge and belief.			
PRINT Name of Local Board Secretary or Chairman	Signature	Date	
PRINT Doctor Name	Signature	Date	

CORRECTIONS OFFICER RETIREMENT PLAN

FORM C5-LB-TP

3010 E. Camelback Rd., Suite 200, Phoenix, AZ 85016

08/11

(602) 255-5575 FAX (602) 296-2369 www.psprs.com

**TOTAL AND PERMANENT
DISABILITY QUESTIONNAIRE**

Completed by Local Board and Doctor (if applicable)

Pursuant to A.R.S. §§ 38-881(44) and 38-886, a "Total and Permanent disability" means a physical condition or mental condition (<i>that is not an accidental disability</i>) that the local board finds totally and permanently prevents a member from engaging in any gainful employment and is in the direct and proximate result of the member's performance of the member's duties.		LOCAL BOARD Initial Response	
1. Did the employee file the application after the disabling incident or within one year of ceasing to be an employee?	YES	NO	
2. Did the employer terminate the member's employment based on a physical or mental condition that is being applied for?	YES	NO	
3. Did the employer terminate the employee's employment based on a disciplinary issue?	YES	NO	
4. Did the member terminate employment based on a physical or mental condition?	YES	NO	
5. Did the member terminate employment based on election to participate in Reverse DROP?	YES	NO	
6. Is the member still working in a job the board believes is gainful employment?	YES	NO	
7. Has the member refused a job the board believes is gainful employment?	YES	NO	
8. Was the condition the direct and proximate result of the member's duty?	YES	NO	
9. Did the condition or injury occur prior to the member's membership in the Plan?	YES	NO	
LOCAL BOARD INSTRUCTIONS: If it is determined that the employee does not qualify, complete FORM C5-LB and forward to CORP. If evidence exists that the employee may qualify, a medical examination (IME) will need to be performed. Sign/date this questionnaire and forward the ORIGINAL (along with the all medical evidence and any additional questions) to the doctor.			
DOCTOR INSTRUCTIONS: In addition to the IME report, answer the following questions, sign/date and return the ORIGINAL to the Local Board. Provide additional comments in the IME report.		DOCTOR Initial Response	
1. Does the member have the physical condition that is the basis for the disability application?	YES	NO	
2. Does the member have the mental condition that is the basis for the disability application?	YES	NO	
3. Does the condition totally prevent the member from engaging in any gainful employment?	YES	NO	
4. Does the condition permanently prevent the member from engaging in any gainful employment?	YES	NO	
5. Did your review include a medical report describing any conditions or injuries that existed prior to membership in the pension system? If yes, address in IME report.	YES	NO	
6. Did any pre-existing conditions or injuries play a role in the disability claimed by the member? If yes, address in IME report.	YES	NO	
7. Did your review determine the member may be able to return to work in the next 12 months? If no, address in the IME report.	YES	NO	
8. Was the condition or injury in the direct and proximate result of the member's performance of their duties?	YES	NO	
9. Are there conflicts in the medical evidence? If yes, address in IME report.	YES	NO	
LOCAL BOARD: If conflicts in the medical evidence, address if and how they were resolved in the Local Board meeting minutes. LOCAL BOARD AND DOCTOR: By my signature below, I attest that the medical records have been thoroughly reviewed, each section/questions have been answered by the appropriate party indicated above, and the information contained herein is true, complete and correct to the best of my knowledge and belief.			
PRINT Name of Local Board Secretary or Chairman	Signature	Date	
PRINT Doctor Name	Signature	Date	

**ORDINARY
 DISABILITY QUESTIONNAIRE**

Completed by Local Board and Doctor (if applicable)

Pursuant to A.R.S. §§ 38-881(30) and 38-886.01, an "Ordinary disability" means a physical condition that the local board determines will totally and permanently prevent an employee from performing a reasonable range of duties within the employee's department or a mental condition that the local board determines will totally and permanently prevent an employee from engaging in any substantial gainful activity.		LOCAL BOARD Initial Response	
1. Did the employee file the application after the disabling incident or within one year of ceasing to be an employee?		YES	NO
2. Does the employer have any jobs available for the member the board believes is a reasonable range of duties position? (Submit job descriptions and duties to doctor.)		YES	NO
3. Has the member refused a job the board believes is a reasonable range of duties?		YES	NO
4. Did the employer terminate the employee's employment based on a physical or mental condition that is being applied for?		YES	NO
5. Did the employer terminate the employee's employment based on a disciplinary issue?		YES	NO
6. Did the member terminate employment based on a physical or mental condition?		YES	NO
7. Did the member terminate employment based on election to participate in Reverse DROP?		YES	NO
8. Does the physical condition totally prevent the member from performing a reasonable range of duties within the employee's department?		YES	NO
9. Does the physical condition permanently prevent the member from performing a reasonable range of duties within the employee's department?		YES	NO
10. Does the mental condition totally prevent the member from engaging in any substantial gainful activity?		YES	NO
11. Does the mental condition permanently prevent the member from engaging in any substantial gainful activity?		YES	NO
LOCAL BOARD INSTRUCTIONS: If it is determined that the employee does not qualify, complete FORM C5-LB and forward to CORP. If evidence exists that the employee may qualify and no reasonable range of duty jobs are available, a medical examination (IME) will need to be performed. Sign/date this questionnaire and forward the ORIGINAL (along with the all medical evidence and any additional questions) to the doctor.			
DOCTOR INSTRUCTIONS: In addition to the IME report, answer the following questions, sign/date and return the ORIGINAL to the Local Board. Provide additional comments in the IME report.		DOCTOR Initial Response	
1. Does the member have the physical or mental condition that is the basis for the disability application?		YES	NO
2. Does the physical condition permanently prevent the member from performing a reasonable range of duties within the employee's department?		YES	NO
3. Does the physical condition totally prevent the member from performing a reasonable range of duties within the employee's department?		YES	NO
4. Does the mental condition totally prevent the member from engaging in any substantial gainful activity?		YES	NO
5. Does the mental condition permanently prevent the member from engaging in any substantial gainful activity?		YES	NO
6. Are there conflicts in the medical evidence? If yes, address in IME report.		YES	NO
LOCAL BOARD: If conflicts in the medical evidence, address if and how they were resolved in the Local Board meeting minutes. LOCAL BOARD AND DOCTOR: By my signature below, I attest that the medical records have been thoroughly reviewed, each section/questions have been answered by the appropriate party indicated above, and the information contained herein is true, complete and correct to the best of my knowledge and belief.			
PRINT Name of Local Board Secretary or Chairman	Signature	Date	
PRINT Doctor Name	Signature	Date	