Mendocino County Employees' Retirement Association

Disability Retirement Application Handbook

Mendocino County Employees' Retirement Association
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Disability Handbook Contents

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The Mendocino County Employees' Retirement Association (MCERA) is governed by the County Employees' Retirement Law (CERL) of 1937 (Government Code Section 31450 et. seq.). Disability and retirement laws are complex.

No statement in this handbook is a legally binding interpretation, enlargement or amendment of the provisions in the CERL or MCERA's policies. If conflict arises between these procedures and the CERL, the decision will be based on the CERL and other governing law.

The information presented in this handbook should not be construed as legal advice or as a legal opinion on specific facts. For legal advice regarding specific facts, consult an attorney knowledgeable in disability retirement law matters.

Please note: You can expect it to take several months to process a disability retirement application.

General Information

This handbook is designed to provide general information about disability retirement. It is *not* a complete summary of all the rules and procedures relating to the disability retirement process. For a more thorough discussion, please refer to the Procedures for Disability Retirement and Applications, which are found in this handbook.

Permanent Disability

In order to be eligible for disability retirement benefits, you must be permanently incapacitated. Permanent incapacity means the substantial and permanent inability to perform the usual duties of your job class specification. If your department is able to accommodate your restrictions, you are not considered to be permanently incapacitated.

Service-Connected Disability Retirement

If you are permanently incapacitated, physically or mentally, from performing your job duties, and your incapacity is the result of a job-related injury, illness or disease, you may be eligible for a service-connected disability retirement benefit, regardless of your age or length of service. Your incapacity must arise out of and in the course of your employment. To prove service connection, there must be substantial evidence of a real and measurable connection between your disability and the activities associated with your job.

Nonservice-Connected Disability Retirement

If your permanent incapacity is not job-related, you may be eligible for a nonservice-connected disability retirement benefit. To receive this benefit, you must have at least five years of retirement service credit, which may include reciprocal retirement service credit.

Application for Disability Retirement

An application for disability retirement must be filed by you, by the head of your department or by any person on your behalf. An application must be filed:

- While you are in service; or
- Within four months after discontinuance of service; or
- At any time if, from the date of discontinuance of service to the time the application is filed, you demonstrate you have been continuously physically or mentally incapacitated to perform your job duties; or
- Within four months after the expiration of the period during which any of the following presumptions, if applicable, are extended beyond your discontinuance of service.

Presumptions Applicable to Safety Members

If you are a Safety member or a member in active law enforcement (or a County probation officer in the case of the blood-borne infectious disease presumption) and you have completed a combined five years or more of service as a member of MCERA or a reciprocal retirement system, one of the following presumptions may apply, provided that you otherwise satisfy the requirements of the presumption, including permanent incapacitation:

- Blood-borne infectious disease
- Heart trouble
- Cancer
- Exposure to biochemical substances

If you feel there is a possibility that one of these presumptions may apply to you, a MCERA service representative can provide you with additional information.

Burden of Proof

The burden of proof on issues of permanent incapacity and service connection is placed on the applicant by law. The amount and nature of the medical evidence you submit to the Board of Retirement to substantiate your claim is at your discretion. If you are filing your own application, you must prove by a preponderance of the evidence that you are permanently incapacitated. If your department or some other person is filing on your behalf, it is their obligation to prove by a preponderance of the evidence that you are permanently incapacitated.

"Proof by a preponderance of the evidence" means proof which leads the trier of fact to become persuaded that, considering all of the evidence in the case, it is more probable than not that you are permanently incapacitated. If your application is for a service-connected disability retirement, you must also prove by a preponderance of the evidence that your incapacity is due to a job-related injury, illness or disease. If the application is filed by your department or someone else for you (see Gov. Code §31721), it is still your obligation to prove that your incapacity is service-connected.

Please be aware that even though workers' compensation or Social Security may have found you disabled, this decision is not binding on MCERA. Although workers' compensation and disability retirement laws may be similar, they are not the same, and it is not unusual for the Board of Retirement to find that a person is not permanently incapacitated even after they have been granted an award by workers' compensation or Social Security.

Please note: Awards for disability from Workers' Compensation and/or Social Security are not applied to any benefit received from MCERA.

Issues the Board Will Consider in Deciding Permanent Incapacitation

The Board will review all pertinent medical reports and records, including those submitted by you and any additional medical reports that may be obtained by MCERA staff. Other documents that may be considered include: personnel records, department head statements, documents relating to any workers' compensation claims, and any investigator's reports.

The Board will look at what employment, if any, you were engaged in after you left service to see if you were performing activities you claimed you were unable to perform because of a disability.

In addition, if you are granted a disability retirement benefit and you are under age 55, MCERA can require you to submit to a medical re-evaluation. If the Board determines you are no longer permanently incapacitated, your disability retirement can be canceled, but only if your employer agrees to reinstate you to your former position which was evaluated in the disability process.

Disability Application Process

Step 1. Application for Disability Retirement

To apply for a disability retirement, a Disability Retirement Application must be submitted to MCERA. An application can be obtained by contacting MCERA. The application packet includes the following documents:

- Application for Disability Retirement Checklist
- Application for Disability Retirement
- Authorization for Release of Medical Records and Information
- Attending Physician Report (APR)
- Disability Retirement Benefit Options & Beneficiary Designation
- Frequently Asked Questions

The member must submit their job description to their physician to use when filling out the Attending Physician Report. Both the Application for Disability Retirement and the Attending Physician Report must be completed, signed and submitted together for the application to be accepted.

An incomplete or altered application will be returned to the member in its entirety. This will delay the processing of the application and may delay the effective date for benefits. It is the applicant's responsibility to supply any medical records to substantiate a disability. Costs associated with copying such records are the responsibility of the member. MCERA may request copies of medical records directly from physicians.

Step 2. Discovery and Obtaining Records

MCERA and its medical consultant, Managed Medical Review Organization Incorporated (MMRO) may obtain all or some of the following records:

1. Records from Risk Management
2. Personnel records
    a. Performance evaluations
    b. Grievance filings
    c. Internal investigations
    d. Accommodations records
    e. Payroll records
3. Workers' compensation
    a. Benefits awards
    b. Notice of work restrictions
    c. All claims filed
4. Report from department head
    a. Includes information regarding accommodation or alternative employment
    b. Description of actual job duties/ job analysis

Step 3. Disability Application Review Process

MCERA staff will review the file for completeness and will certify that the application meets the requirements to file for disability retirement. Incomplete applications that do not meet requirements may be returned to member.

MCERA and its medical consultant, Managed Medical Review Organization Incorporated (MMRO) may obtain additional evidence, where necessary including medical and personnel records (see Step 2), or it may request an additional medical evaluation or investigation. Upon receipt of the additional information, MCERA and its medical consultant, Managed Medical Review Organization Incorporated (MMRO) may refer the application to an independent medical advisor to summarize the medical evidence and provide an opinion on permanent incapacitation and, where appropriate, service connection.

Step 4. Board Meeting

Once the member's application has been deemed complete, it will be placed on the Board of Retirement's Closed Session agenda.

The member will be advised of the date and time that the Board will consider the application. The member does not need to be present at the meeting. Oral testimony is <u>not</u> taken at the Board meeting. The member will be notified by mail of the Board's decision.

Disability Application Process

Step 5. Board Denial and Administrative Hearing

If an applicant is denied a disability retirement based on lack of permanent incapacitation or failure to prove service connection, a letter will be sent no later than three working days after the decision, advising the applicant of his/her right to an administrative hearing.

This administrative hearing is held before a hearing officer. After the hearing is held, the hearing officer will make a recommendation on the disability retirement application to the Board.

The matter will then be placed on the Retirement Board's agenda for a final determination.

Step 6. Judicial Review

If the Board's final determination following Administrative Hearing is to deny application for disability, a letter will be sent no later than three working days after the decision advising the applicant of his/her right to judicial review. This letter will include notice of the time limitation for filing for judicial review by writ of mandate.

Judicial review of final retirement decisions shall be subject to the Code of Civil Procedure section 1094.6, which means that if you want to challenge the Board's decision, you must file an action in Superior Court within 90 days of final determination.

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Application for Disability Retirement Checklist

Disability Application Requirements. In order for MCERA to accept and deem your application for disability retirement complete, you must submit the following required documents.

- ☐ **Application for disability retirement** – Incomplete applications will not be accepted. All questions on the application must be answered, and responses must be legible. Reports and documentation submitted as attachments must also be legible.
- ☐ **Authorizations for use and disclosure of information and Attending Physician Report --** Must be submitted with the application.
- ☐ **A Delayed Disability Application Affidavit (Included in the Attending Physician Report) --** Must be completed by the member and the treating physician if more than four (4) months have elapsed from the member's last day of service to the filing of the disability application. The treating physician must state that the member has been physically or mentally disabled from performing his/her usual job duties since the date he/she discontinued service.
- ☐ **A copy of the member's job class specification --** Must be submitted with the application. Departments and Human Resources can provide this information.
- ☐ **All supporting medical records and reports** – The applicant must demonstrate that he/she is permanently disabled from substantially performing the usual duties of his/her job. For a service-connected disability, the documentation must demonstrate that the employment contributed substantially to the disability. The applicant must submit all medical records to support his/her disability case at the time the disability application is filed.
- ☐ **A disability retirement options & beneficiary designation --** Must be submitted with the application.
- ☐ **Certified copies of birth certificate, certificate of marriage or domestic partnership, and birth certificate for spouse or partner if eligible for continuance --** Must be submitted with the application. MCERA staff may copy and return your originals.

IMPORTANT NOTE

Failure to submit the above documents will deem your Application for Disability Retirement incomplete and unacceptable.

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Application for Disability Retirement

FOR MCERA USE ONLY
Years of Service:

Member Name: _____

I am applying for disability retirement because I believe I am permanently disabled from performing the usual duties of my assigned job.

Applicant Signature**:** _____ Date**:** _____

Section 1: General Information. If address changes during disability process, you must notify MCERA in writing.

Street Address			Social Security Number ___ ___
City	State	Zip	Birth Date (mm/dd/yyyy)
Home Phone Number ( )	Work Phone Number ( )		Cell Phone Number ( )
Email Address (optional)			

Section 2: Application Type. Please indicate type(s) of disability retirement you are applying for.

Nonservice-Connected Disability Retirement

☐
- Injury/Illness that was not incurred at work.
- Five (5) years of service required, per California Government Code §31720(b).

Do you have five (5) years of service?

Yes ☐ No ☐ Unsure ☐

Service-Connected Disability Retirement*

☐
- Injury/Illness that was incurred at work.
- No minimum years of service required.

If the Board of Retirement finds you to be permanently incapacitated, but not on a service-connected basis, you will be granted a nonservice-connected disability retirement if you have at least five years of service.

* By Applying for Service-Connected Disability Retirement, Applicant is also applying for Nonservice-Connected Disability Retirement if the Board finds no service-connection for the disability.

Section 3: Current employment. Please provide the following information about your current employment.

Permanent Position Disabled From: _____

Department: _____ **Immediate Supervisor:** _____

Membership Status: ☐ **General** ☐ **Safety**

Original Date of Employment: _____ **Date Assigned to Most Recent Position:** _____

Since your original date of employment, was there a time when you were not employed by this employer or you were on an extended leave of absence? *Please check one box:*

☐ Yes ☐ No If yes, please explain: _____

_____

***** PLEASE COMPLETE APPLICATION IN INK *****

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Section 4: Reciprocity. When a member who has established reciprocity with MCERA and another retirement system retires on disability, under California Government Code §31838.5, each system is required to pay only its proportional share of the disability payment, based on the portion of the overall combined service that was earned in each system. The member may not receive a total benefit amount for more than what they would have received had all service been earned in one retirement system.

Please check and complete all that apply:

☐ I am currently an active member of MCERA and have reciprocity with _____.

☐ I am currently a reciprocal member of MCERA and an active member of: _____

☐ Reciprocity does not apply.

If you are an active member of MCERA, please continue to complete the rest of the application. If you are a deferred member of MCERA, you may stop filling out the application. MCERA requires verification from the reciprocal agency of your disability benefit, including the type (service- or nonservice-connected), effective date, final average salary used, years of service credited in the agency, and monthly benefit amount.

Section 5: Current status. Please check any of the following that applies to you, and answer the questions.

☐ **Currently receiving retirement benefits.** Are you currently receiving any retirement benefits? If yes, please specify the company (or employer) and the type of retirement.

_____

_____

☐ **Terminal illness.** Check if you are currently suffering from a terminal illness and have medical documentation regarding your status.

Section 6: Effective Date. If you are ultimately granted a disability retirement, your disability retirement allowance shall be effective as of the date your application is filed with MCERA or the date following your last day of compensation. You may request an earlier effective date when that date is earlier than the date your application is accepted. However, you must demonstrate that the filing of your application was delayed by administrative oversight or by an inability to ascertain the permanency of your incapacity.

If you are requesting an earlier effective date, you must provide the information requested:

☐ **I request an earlier effective date**. I have attached the following information:

- ☐ Medical report or documentation stating when my injury or illness became permanent, or
- ☐ No such documentation exists. I have attached documentation showing my injury is not yet permanent, or
- ☐ Documentation demonstrating that filing delay was caused by administrative oversight, and
- ☐ Documentation regarding my last day of compensation, which was: _____

☐ **I am not requesting an earlier effective date**.

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Section 7: Purchase of Service. Eligibility for non service-connected disability requires five (5) years of credited service with MCERA. If you have previously withdrawn or received money accumulated during prior service years, you may be able to purchase those years of service. If you must purchase service years to achieve eligibility and have service years available to buy, you must do so prior to completing this application in order to receive credit for those previously withdrawn service years. [See Gov. Code §31652(a).]
Important notice: Read carefully: Failure to purchase service years prior to completing this disability retirement application will constitute a waiver of your rights to redeposit those contributions.

☐ I understand that I may purchase contributions previously withdrawn from MCERA prior to completing my disability retirement application in order to receive credit for those additional service years.

☐ I do want to purchase contributions previously withdrawn from MCERA.

Section 8: Notice of right to legal representation. You are not required to have an attorney at any time to apply for a disability retirement. However, you are entitled, at your own expense, to be represented by legal counsel at any and all stages of the disability proceedings. Should you choose to be represented by legal counsel, you must file a written notice with MCERA regarding the hiring, changing or dismissal of counsel. Once written notification is received by MCERA that you have legal counsel, all notices, correspondence and documents shall be sent to that attorney. Absent such written designation, MCERA is not obligated to recognize any attorney claiming to represent you. If you decide to change attorneys or no longer wish to be represented by a specific attorney, you must notify MCERA in writing.

I understand that I have the right to be represented by legal counsel at any and all stages of the disability proceedings.

Please choose one:

☐ I am not represented by legal counsel at this time. I understand that should I later choose to be represented by counsel, I must file a written notice of the hiring of counsel with MCERA.

Applicant Signature: _____ Date: _____

☐ I am represented by legal counsel for my disability retirement process. His/Her contact information is listed below. I hereby authorize my attorney to receive copies of all notices, correspondence, and documents relevant to my disability application. I understand that MCERA will also contact me directly. I acknowledge that this authorization may be revoked at any time by me in writing.

Name: _____ Firm: _____

Address: _____ Phone: _____

Applicant Signature: _____ Date: _____

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Section 9: Current Work status with MCERA employer. Please check the appropriate section(s), and provide the information requested.

Are you still receiving a paycheck, including sick leave and vacation time? ☐ Yes ☐ No

If no, when did you receive your last paycheck? _____

When was the last day you actually worked? _____

Please complete the following if you are currently working.

I am currently working_____hours per week, as follows:

- ☐ Usual and customary work, or
- ☐ Modified work. Effective date of modified duty: _____

  The modified duty is: ☐ Temporary ☐ Permanent

Please complete the following if you are currently not working.

I am currently not working, although I am still an employee in the following status:

- ☐ Regular sick leave. Approximate date your leave will end: _____
- ☐ Leave without pay. Date your paid compensation ended: _____
- ☐ Leave with pay/administrative leave. Reason: _____
- ☐ Labor Code Section 4850 (leave with compensation).

  Effective date:_____ Approximate date your leave ends: _____
- ☐ Temporary disability (workers' compensation)

  Effective date:_____ Approximate date your leave ends: _____
- ☐ Permanent disability (workers' compensation)

  Date deemed permanent and stationary:_____*(please submit copy of doctor's report)*
- ☐ State disability
- ☐ Other (please specify): _____

(Section 9 continues on next page)

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Section 9: Current Work status with MCERA employer (continued)

Please complete the following if you are no longer employed with the County or other MCERA special district.

☐ I resigned from my employment. If so, please specify effective date of termination and reason for leaving:

_____

_____

☐ I was terminated from my employment for cause or I am in the process of being terminated.

Effective date of termination: _____

☐ I took a regular service retirement.

Effective date of service retirement: _____

Section 10: Present Non-MCERA Employment. If you are presently working for an employer other than the County of Mendocino or a MCERA special district (including self-employment, non-compensated work or any other circumstances in which you may perform services for money or other compensation), please provide the following information: employer name, address and telephone number; dates of employment; and type of work.

Name of Employer	Address of Employer	Phone # of Employer	Dates of Employment	Type of Work

Section 11: Injury / Illness. A permanent disability may be the result of an injury, illness or disease. The cause may or may not be work-related. Please complete the following section for each and every injury, illness or disease that forms the basis of your disability application. If additional pages are required, please check the box below and provide the requested information on a separate page.

Each injury/illness that causes your permanent disability *must be listed separately* on pages 10-14. Use additional pages as needed. Indicate the number of additional pages you are attaching:_____.

Injury / Illness #1, Primary medical condition which causes permanent disability and/or permanent work restrictions.

Injury / Illness type: _____

Description of injury / illness: _____

When did you first experience symptoms? _____

Date you first became disabled: _____

(Section 11 continues on next page)

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Application for Disability Retirement

Section 11: Injury / Illness (continued)

Physician(s) Treating Injury / Illness	Phone Number	Treatment Date(s)

If you are receiving ongoing medical or therapeutic treatment pertaining to the injury, illness or disease for which you are applying, please provide the information requested below:

Type of Treatment / Therapy	Name of Health Care Provider	Phone Number

Is your disability the result of a disease? ☐ Yes ☐ No

If yes, please provide the following information:

(a) Description of the disease: _____

_____

_____

(b) When did you first experience symptoms of the disease? _____

_____

(c) The date the disease was first diagnosed and the name of the diagnosing physician: _____

_____

(Section 11 continues on next page)

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Section 11: Injury / Illness (continued)

Is your disability the result of an injury or injuries? ☐ Yes ☐ No

If yes, please provide the following information:

(a) The date, time of day and location the injury occurred: _____

_____

(b) How and why the injury occurred: _____

_____

(c) The name, address and telephone number of all witnesses to the injury: _____

_____

_____

_____

Do you feel your employment caused or contributed to your injury / illness? ☐ Yes ☐ No

If yes, please describe how: _____

_____

_____

_____

_____

_____

_____

_____

Have you ever had a similar injury, disease, symptom, complaint, disability or other condition? ☐ Yes ☐ No

If yes, for each such prior injury or condition, please describe: _____

_____

_____

_____

_____

_____

_____

(Section 11 continues on next page)

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Section 11: Injury / Illness (continued)

Injury / Illness #2, Secondary medical condition which causes permanent disability and/or permanent work restrictions.

Injury / Illness type: _____

Description of injury / illness: _____

When did you first experience symptoms? _____

Date you first became disabled: _____

Physician(s) Treating Injury / Illness	Phone Number	Treatment Date(s)

If you are receiving ongoing medical or therapeutic treatment pertaining to the injury, illness or disease for which you are applying, please provide the information requested below:

Type of Treatment / Therapy	Name of Health Care Provider	Phone Number

Is your disability the result of a disease? ☐ Yes ☐ No

If yes, please provide the following information:

(d) Description of the disease: _____

_____

(e) When did you first experience symptoms of the disease? _____

(f) The date the disease was first diagnosed and the name of the diagnosing physician: _____

_____

_____

(Section 11 continues on next page)

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Section 11: Injury / Illness (continued)

Is your disability the result of an injury or injuries? ☐ Yes ☐ No

If yes, please provide the following information:

(a) The date, time of day and location the injury occurred: _____

_____

(b) How and why the injury occurred: _____

_____

(c) The name, address and telephone number of all witnesses to the injury: _____

_____

_____

_____

Do you feel your employment caused or contributed to your injury / illness? ☐ Yes ☐ No

If yes, please describe how: _____

_____

_____

_____

_____

_____

_____

_____

Have you ever had a similar injury, disease, symptom, complaint, disability or other condition? ☐ Yes ☐ No

If yes, for each such prior injury or condition, please describe: _____

_____

_____

_____

_____

_____

_____

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Section 12: Permanent incapacity from performing Job Duties (To be eligible for a disability retirement, applicant must demonstrate that he/she is permanently disabled from substantially performing the essential duties of his/her job. Please answer the questions below concerning the permanency of your claimed injury/illness.)

Please describe, in your own words, all of the usual duties of your employment at the time you became disabled (include only those activities that you were actually required to perform and those you actually did perform). *Do not substitute a job description for this answer. You may include a Job Analysis, if available.*

Do you believe that you are permanently disabled from performing one or more of the duties described in response to the previous question? ☐ Yes ☐ No

You must have documentation (a letter or other documentation from a medical provider) containing an opinion on the permanency of your condition and that you are unable to perform your essential job duties. If you are applying for a service-connected disability retirement, documentation should also include the manner in which your condition is job-related.

Are you scheduled for surgery for the injury/illness claimed or has any medical provider recommended surgery for your condition? ☐ Yes ☐ No

In your own words, please state which duties you cannot perform as a result of your injury/illness.

What accommodation(s) do you feel could be made that would allow you to return to work?

Have these accommodations been discussed with your department? ☐ Yes ☐ No

If yes, when? What were the results?

At any time since you first became disabled, has your condition improved enough so that you would have been capable of performing your usual duties? ☐ Yes ☐ No

If yes, when?

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Section 13: Medical treatment other than listed Injury/Illness Within last five (5) years

Were you examined or treated by any health care provider for any reason within the five years immediately before the injury or illness that is the basis for your application for disability retirement? ☐ Yes ☐ No

If yes, for each such provider, please state the following: name; address; date (or date range) of examination or treatment; and a description of each symptom, complaint or other condition for which you were examined or treated.

Health Care Provider Name	Address	Date(s) of Examination or Treatment	Description of Complaint, Symptom, Condition

Provide the following information for each health care provider you have seen for any reason other than routine medical services since the onset of the injury or illness that is the basis for your disability retirement application. Please state the following: name; address; date (or date range) of examination or treatment; and a description of each symptom, complaint or other condition for which you were examined or treated.

Health Care Provider Name	Address	Date(s) of Examination or Treatment	Description of Complaint, Symptom, Condition

****** Do not complete Section 14 if you are a General Member. ******

Section 14: Safety Member's Injury / Illness (If you are a safety member who has completed five (5) or more years of service in MCERA or another California public pension plan, please answer the questions below.)

Section 14.1 Is this application based on heart trouble? ☐ Yes ☐ No

Section 14.2 Is this application based on a disability related to any cancer? ☐ Yes ☐ No

Section 14.3 Is this application based on a blood-borne infectious disease? ☐ Yes ☐ No

Section 14.4 Is this application based on an exposure to a biochemical substance? ☐ Yes ☐ No

Section 14.5 I am an eligible safety member applying for a service-connected disability based on one of the above presumptions. ☐ Yes ☐ No

Initial _____

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Application for Disability Retirement

Section 15: Other Claims Filed

Please check any claim(s) you have filed related to the injury, illness or disease that is the basis for your application for disability retirement, and indicate the date it was filed:

		Date Filed			Date Filed
☐	Workers' compensation	_____	☐	Social Security	_____
☐	Long-term disability	_____	☐	Unemployment	_____
☐	State disability	_____	☐	Other pending claim or legal action against employer	_____

For each such claim or action, please give the following information:

(a) The nature of the claim or action: _____

_____

_____

(b) The name and address of the court, company or agency where the claim or action was filed: _____

_____

_____

For multiple claims, please continue on a separate page.

Section 16: Miscellaneous

Do you have any hobbies? If yes, please list: _____

Do you play sports? If yes, please list: _____

Do you engage in any physical activities? If yes, please list: _____

_____

In the past 15 years, have you engaged in any hobbies, sports and/or physical activities? If yes, please list all: _____

_____

_____

_____

Did you have any other job(s) or engage in any non-County work while employed by and MCERA Employer? If yes, please describe the type of work and its duration: _____

_____

_____

_____

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Application for Disability Retirement

Section 17: Additional Information

Please include any further information that might aid the Board of Retirement in making a determination on your application for disability retirement: _____

_____

_____

_____

Section 18: Declaration

I declare under penalty of perjury that the foregoing responses contained in this application for disability retirement are true and correct, and that this declaration was signed on _____, in _____, California.
(Month Day, Year) *(City)*

PROCESSING OF THIS DISABILITY APPLICATION IS CONTINGENT UPON RECEIPT OF A COMPLETED DISABILITY APPLICATION, ATTENDING PHYSICIAN REPORT(S) AND SUPPORTING MEDICAL DOCUMENTATION.

_____	_____	_____
Applicant Signature	Applicant Name *(please print)*	Date

FOR MCERA USE ONLY

Certification by Retirement Association

The official retirement records of this applicant have been reviewed, and the application meets the requirements to file for disability retirement.

Yes _____ No _____ *(reviewer's initials)*

Date Reviewed: _____

Mendocino County Employees' Retirement Association
625-B Kings Ct. · Ukiah, CA 95482 · (707) 463-4328 · Fax (707) 467-6472

AUTHORIZATION FOR USE OR DISCLOSURE OF PERSONNEL INFORMATION

I, _____, hereby authorize disclosure of any and all information or records relating to my employment with the _____ to the Mendocino County Employees' Retirement Association (MCERA) and its medical consultant, Managed Medical Review Organization Incorporated (MMRO), for the purposes of processing my disability retirement application and to assist the Board of Retirement in making a determination regarding my eligibility for disability retirement.

These records include but are not limited to: Personnel files, performance evaluations, information in connection with job applications, accident/injury reports, workers' compensation claims filed and any medical records including application for accommodations and correspondence related to disability, Family Medical Leave (FMLA) and supporting documents, fit for duty evaluations, disciplinary actions, letters of counseling or reprimand, eligibility for rehire, letters or memoranda to the employee, letters or memoranda to the employer, information regarding complaints or claims, statements of supervisors or co-workers, or administrative records.

I understand and agree that this authorization shall remain in force until a final determination is made regarding my disability retirement application. However, in no event shall this consent be valid for a period in excess of two (2) years from the date of its execution. I further understand that I have a right to receive a copy of this authorization and that I may obtain copies of the information that I am being asked to allow use or disclosure of upon my request.

I understand that I may revoke this authorization at any time, but I must do so in writing and submit to the Mendocino County Employees' Retirement Association (MCERA) at 625-B Kings Court, Ukiah, CA 95482. I further understand that if I revoke this authorization for any reason, I will not be in compliance with the disability application procedure and process; therefore my pending disability application may be returned to me or denied by the Board of Retirement.

PLEASE NOTE: SIGNATURE MUST BE WITNESSED ON SAME DATE

_____
Applicant Name (Please Print)

_____ _____
Applicant Signature Date Signed

_____ _____
Witness Date Signed
(Must be at least 18 years of age and not beneficiary)

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AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

I, _____, hereby authorize disclosure of any and all information or records relating to my Worker's Compensation Case held by York Risk Services Group, Inc. (Workers Compensation Carrier) to the Mendocino County Employees' Retirement Association (MCERA) and its medical consultant, Managed Medical Review Organization Incorporated (MMRO), for the purposes of processing my disability retirement application and to assist the Board of Retirement in making a determination regarding my eligibility for disability retirement.

I understand and agree that this authorization shall remain in force until a final determination is made regarding my disability retirement application. However, in no event shall this consent be valid for a period in excess of two (2) years from the date of its execution. I further understand that I have a right to receive a copy of this authorization and that I may obtain copies of the information that I am being asked to allow use or disclosure of upon my request.

PLEASE NOTE: SIGNATURE MUST BE WITNESSED ON SAME DATE

_____
Applicant Name (Please Print)

_____ _____
Applicant Signature Date Signed

_____ _____
Witness Date Signed
(Must be at least 18 years of age and not beneficiary)

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AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

Explanation:
This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code section 56 *et seq.*

I, _____, hereby authorize use or disclosure of any and all medical records and information pertaining to my medical history, any disability or medical condition, mental or physical conditions, services rendered or treatment of myself to the Mendocino County Employees' Retirement Association (MCERA) and its medical consultant, Managed Medical Review Organization Incorporated (MMRO), for the purposes of processing my disability retirement application and to assist the Board of Retirement in making a determination regarding my eligibility for disability retirement. I further give my informed consent and authorize MCERA and its medical consultant, MMRO, to provide any of the aforementioned information to any independent medical examiners and consultants retained by MCERA or MMRO to assist in evaluation of my application for disability retirement.

I understand and agree that this authorization shall remain in force until a final determination is made regarding my disability retirement application. However, in no event shall this consent be valid for a period in excess of two (2) years from the date of its execution. I further understand that I have a right to receive a copy of this authorization and that I may obtain copies of the information that I am being asked to allow use or disclosure of upon my request.

PLEASE NOTE: SIGNATURE MUST BE WITNESSED ON SAME DATE

_____
Applicant Name (Please Print)

_____ _____
Applicant Signature Date Signed

_____ _____
Witness Date Signed
(Must be at least 18 years of age and not beneficiary)

Mendocino County Employees' Retirement Association
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Attending Physician Report

To qualify for a disability retirement, the MCERA member must be substantially incapacitated from the performance of the usual duties of his/her position. A person's incapacity is permanent if change for the better or worse is not to be reasonably anticipated under usual standards. It is not necessary that the person be physically or mentally incapable of performing each and every duty or task that might arise within the job classification.

Part 1: Applicant to Complete

Member's authorization for the release of medical information in connection with submission of attending physician report.

Member Name: _____ **Date of Birth:** _____

To: _____ (Name of physician completing report)

You are hereby authorized to release directly to the Mendocino County Employees' Retirement Association (MCERA) and its medical consultant, Managed Medical Review Organization Incorporated (MMRO) this completed Attending Physician Report (APR). I understand that the information you provide therein will be used to determine my eligibility for disability retirement and that the medical information and APR may be disclosed to the following: Managed Medical Review Organization (MMRO), MCERA staff, counsel, hearing officers, physicians, other consultants, and the Board of Retirement.

Member Signature: _____ **Date:** _____

Printed Member Name: _____ **Phone:** _____

***** This report must be typed or printed legibly and signed by a duly licensed medical doctor. *****

Part 2: Physician to Complete

Physician Acknowledgement

Full Name of Patient: _____

Please identify the claimed disability (i.e., injury, illness and/or disease) for which you are evaluating this patient. Please be specific as to any body part that forms the basis of this application: _____

_____

_____

_____

Date of last visit: _____

Been treating patient since: _____

Name of all persons completing this form: _____

☐ Please check this box to confirm that you have reviewed the member's application for disability retirement.

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Attending physician report (continued)

Member Information (Section must be completed. Reports can be submitted to support information below.)

1. Describe the patient's current complaints: _____

2. List other medical conditions that may have contributed to the claimed disability: _____

3. Provide the patient's employment history and identify the duties/activities being performed by the patient at the onset of the claimed disability: _____

4. Describe the work duties the patient last performed or is currently performing in service: _____

Member History (Section must be completed. Reports can be submitted to support information below.)

1. Provide a detailed description of your history following the claimed disability: _____

2. Identify all medical records upon which you are relying in forming your opinions: _____

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Attending physician report (continued)

Physical Examination

Did you perform a physical examination? ☐ Yes ☐ No Date: _____

Explain the examination performed and your findings: _____

_____

_____

_____

_____

_____

_____

Diagnosis

Identify the diagnosis related to the claimed disability (i.e., illness, injury or disease): _____

_____

_____

_____

_____

_____

_____

_____

Permanent Incapacity

1. Is the applicant permanently incapacitated from performing his/her usual duties? ☐ Yes ☐ No

2. Do you expect a change in the patient's claimed disability?

☐ No

☐ Yes, for the better. Please explain and include anticipated timeframe for change: _____

_____

☐ Yes, for the worse. Please explain and include anticipated timeframe for change: _____

_____

_____

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Attending physician report (continued)

Permanent Incapacity (continued)

3. Is there any treatment that might permit the patient to return to full duty?

☐ No

☐ Yes, please describe the treatment, its availability and acceptance in the medical community. Also, please estimate the time and requirements for a recovery and advise whether the benefits of treatment clearly outweigh the risks of treatment:

4. Please discuss in detail if any reasonable accommodations or reasonable medical treatment, including surgery, can be made that would allow the patient to accomplish the job duties listed in Section 12 of the disability application. Your discussion should identify precisely what the recommended treatment consists of and the probability that the applicant can return to his/her former job.

5. Based on the review of the patient's job description, please list the permanent restrictions/limitations (prophylactic or otherwise) required by the patient as a result of the claimed disability. If this application is based on more than one condition, please match the required restriction/limitation with the corresponding claimed disability. Please be specific.

Examples: "Patient cannot lift more than 20 pounds due to lower back pain" or "Patient is unable to type more than four hours in an eight-hour workday due to condition of the upper extremities."

6. If the patient is unable to perform any of the essential job functions described in the patient's job description, is the patient able to perform any other kind of work? ☐ No ☐ Yes, please explain below:

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Attending physician report (continued)

Causation (Please complete ONLY for service-connected disability retirement claims.)

1. What, if any, is the connection between the patients's claimed disability and his/her employment? _____

_____

_____

Please explain the basis for your finding: _____

_____

Please describe any/all contributing factors: _____

_____

2. Is the patient's claimed disability due to intemperate use of alcohol or drugs? ☐ Yes ☐ No

3. Is the patient's claimed disability due to willful misconduct? ☐ Yes ☐ No

***** Do not complete "Delayed disability" section below if applicant is still actively employed. *****

Delayed Disability Application Affidavit. (This section must be completed by the member's physician if the application is not filed within four (4) months of discontinuation of service.)

Was the applicant continuously physically or mentally incapacitated from performing his/her duties from the date of discontinuance of service to the current date? ☐ Yes ☐ No

Did the incapacitation exist at the time of the discontinuance? ☐ Yes ☐ No

Please provide a copy of all documentation relied upon to conclude that the patient has been continuously incapacitated.

Review of Medical Records

Did you review the applicant's medical records? ☐ Yes ☐ No

Penalty of Perjury Statement

I declare under penalty of perjury that the information contained in this questionnaire and its attachments, if any, are true and correct to the best of my knowledge and belief, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

Printed Name: _____ Date: _____

Signature: _____ Medical ID Number: _____

Mailing Address: _____

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Disability Retirement Benefit Options & Beneficiary Designation

MEMBER INFORMATION					
Name (Last, First MI)	Social Security Number — —	Birth Date	Retirement Effective Date		
Street Address	City	State	Zip		
Department	Membership Type: ☐ General ☐ Safety	Home Phone	Work Phone		
Email address (optional)		Cell Phone (optional)			
Name of Spouse or Registered Domestic Partner	Social Security Number	Birth Date	Date of Marriage/DPA		

ADDITIONAL INFORMATION (Please answer the following questions by checking the appropriate box.)		
Do you have any leaves of absence without pay?	☐ Yes	☐ No
Was your entire service as a member of MCERA rendered on a full-time basis?	☐ Yes	☐ No
Do you have any leaves of absence due to medical reasons?	☐ Yes	☐ No
Have you ever withdrawn contributions?	☐ Yes	☐ No
Have you purchased credit for prior part time/extra help service?	☐ Yes	☐ No
Have you purchased credit for public service prior to MCERA membership?	☐ Yes	☐ No
NOTE: You must notify your department/district of your pending retirement date. I understand that my retirement will not be effective until I notify my department/district and separate from employment. I hereby authorize MCERA to speak with my department/district regarding my date of retirement and the date of my filing an application for disability retirement.	☐ Yes	☐ No

I hereby certify under penalty of perjury that the information submitted is true and correct, and I affirm my consent to release information as provided above.

Member's Signature Date Signed

RETIREMENT OPTIONS (Please contact MCERA for additional information.)

Choose your retirement option: ☐ Unmodified ☐ Option 1 ☐ Option 2 ☐

Do you wish to begin service retirement, if eligible, while your disability application is pending? ☐ Yes ☐ No

Your monthly retirement allowance will be based upon your retirement option choice. Regardless of which option you choose, you will receive a monthly allowance for the rest of your life. This option cannot be changed after retirement, except to adjust for approval of your application for disability retirement. The retirement options are explained on the next page.

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RETIREMENT OPTIONS (continued)

☐ **Unmodified Allowance** Member Initials _____ Spouse or RDP Initials _____

In general, the unmodified allowance provides for the highest possible monthly retirement benefit during your life. This option provides, upon your death, a lifetime benefit equal to 60% of the benefit you received during retirement to your eligible beneficiary. This survivor benefit is restricted to your eligible spouse, qualified domestic partner or eligible child only. Your spouse or qualified domestic partner are considered eligible if you have been married for at least one year at the time of your retirement and you are married to that spouse at the time of your death. If you do not have an eligible spouse or qualified domestic partner, the 60% benefit may be paid to your eligible child upon your death. An eligible child is an unmarried child under the age of 18, or an unmarried full-time student under the age of 22. If you do not have an eligible spouse, qualified domestic partner or eligible child at the time of your death, your designated beneficiary will receive a lump-sum refund of any of your remaining contributions and interest. Under the Unmodified Option, you may change your designated beneficiary for the death benefit at any time without affect to the 60% benefit payable to an eligible spouse, qualified domestic partner or eligible child.

☐ **Option 1** Member Initials _____ Spouse or RDP Initials _____

This option does not provide a continuance. Upon your death, a lump-sum payment of any remaining contributions becomes payable to your named beneficiary. Each month the annuity portion of your benefit is deducted from your contributions until the balance of your contributions is zero. You will continue to receive your benefit, but there would no longer be a lump-sum benefit payable to your beneficiary. You may change your named beneficiary at any time.

☐ **Option 2** Member Initials _____ Spouse or RDP Initials _____

At the time of your death, your designated beneficiary will receive the same monthly allowance you were receiving at the time of your death for the remainder of his or her lifetime. An Actuary calculation may be required if the named beneficiary is not your spouse and/or they are more than 10 years younger than you. In order to provide this continuance, your benefit is reduced during your retirement based on your life expectancy and the life expectancy of your beneficiary. Should your beneficiary pre-decease you, you will continue to receive the same reduced amount and you will not be allowed to designate a new beneficiary.

I understand that I can not change options once I have received my first benefit check.

I/We elect the following Option: _____

Member Signature: _____ Date: _____

*****The signature of the Spouse or Registered Domestic Partner (RDP) must be notarized unless signed in the presence of a MCERA staff member, with proof of identification.**

Spouse or RDP Signature: _____ Date: _____

MCERA Staff Signature: _____ Date: _____

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Beneficiary Designation Form

Section 1 – Member Information: Complete all applicable information in the section below.

MEMBER INFORMATION: *Please check one:* **ACTIVE** **DEFERRED** **RETIRED**		
Name (Last, First MI)		
Street Address		
City	State	Zip Code
Social Security Number	Birth Date (mm/dd/yyyy)	Telephone Number

Section 2 – Beneficiary Information: Complete all applicable information in the section below. Indicate the primary or contingent beneficiary(ies) by marking the appropriate box next to each person's name. If you name more than one person in either category, you must indicate what percentage of the benefit each individual is to receive. The total percentage for each category must be 100%. If you do not indicate a percentage, the benefit will be divided into equal parts.

1. Provide each beneficiary's name, current address, Social Security #, birth date, relationship to you, and phone #.
2. Submit certified copies of spouse or domestic partner's birth certificate and your certificate of marriage or domestic partnership, if applicable, for your primary beneficiary. MCERA staff may copy and return your originals.
3. If you are deleting a spouse, provide a copy of your Divorce Settlement Agreement or a Certificate of Death.

BENEFICIARY INFORMATION: **PRIMARY**			**PERCENTAGE:** **%**
Name (Last, First MI)			
Street Address			
City	State		Zip Code
Social Security Number	Birth Date (mm/dd/yyyy)	Relationship	Telephone Number

REQUIRED SIGNATURE: *Beneficiary information will not be accepted without your signature.*

Member Signature: _____ Date: _____

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Section 2 – Beneficiary Information (continued): To designate additional beneficiaries, complete sections below.

BENEFICIARY INFORMATION: ☐**PRIMARY** ☐**CONTINGENT** **PERCENTAGE:** **%**

Name (Last, First MI)

Street Address

City | State | Zip Code

Social Security Number | Birth Date (mm/dd/yyyy) | Relationship | Telephone Number

BENEFICIARY INFORMATION: ☐**PRIMARY** ☐**CONTINGENT** **PERCENTAGE:** **%**

Name (Last, First MI)

Street Address

City | State | Zip Code

Social Security Number | Birth Date (mm/dd/yyyy) | Relationship | Telephone Number

BENEFICIARY INFORMATION: ☐**PRIMARY** ☐**CONTINGENT** **PERCENTAGE:** **%**

Name (Last, First MI)

Street Address

City | State | Zip Code

Social Security Number | Birth Date (mm/dd/yyyy) | Relationship | Telephone Number

BENEFICIARY INFORMATION: ☐**PRIMARY** ☐**CONTINGENT** **PERCENTAGE:** **%**

Name (Last, First MI)

Street Address

City | State | Zip Code

Social Security Number | Birth Date (mm/dd/yyyy) | Relationship | Telephone Number

REQUIRED SIGNATURE: *Beneficiary information will not be accepted without your signature.*

Member Signature | Date

Mendocino County Employees' Retirement Association

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Section 3 – Lump Sum Death Benefit: If you are retired and your last active duty was with the County of Mendocino or a participating Special District, the beneficiary you name in Section 3 will receive a one-time $1,000 Lump Sum Death Benefit. This person may be the primary beneficiary you list in Section 2, or it may be someone else. If this section is left blank, your primary beneficiary named in Section 2 will receive this payment.

PRIMARY BENEFICIARY INFORMATION:			**PERCENTAGE: %**
Name (Last, First MI)			
Street Address			
City		State	Zip Code
Social Security Number	Birth Date (mm/dd/yyyy)	Relationship	Telephone Number

BENEFICIARY INFORMATION: ○ **PRIMARY** ○ **CONTINGENT**			**PERCENTAGE: %**
Name (Last, First MI)			
Street Address			
City		State	Zip Code
Social Security Number	Birth Date (mm/dd/yyyy)	Relationship	Telephone Number

Section 4 – Minor or Special-Needs Adult: Complete this section only if you are naming a minor or special-needs adult as your primary beneficiary. Please include a copy of the beneficiary's birth certificate. If you are naming a minor and want to designate an adult to manage payments for the minor without court appointment or supervision until an age you specify, use the following format:

[Name of adult] as custodian for [Name of minor] until age [choose a number between 18 and 25]. Use the adult's address and telephone number and the minor's date of birth, Social Security number and relationship. Or, you may simply name the minor as beneficiary without naming a custodian, in which case court appointment and supervision of a guardian will be required, and all funds will be distributed to the beneficiary at age 18. (Court documents must include the guardian's name, address and telephone number.)

GUARDIAN / CONSERVATOR INFORMATION:			
Name (Last, First MI)			
Street Address			
City		State	Zip Code
Social Security Number	Birth Date (mm/dd/yyyy)	Relationship	Telephone Number

Note: Beneficiary information will not be accepted without the required signature at the bottom of each page.

REQUIRED SIGNATURE: *Beneficiary information will not be accepted without your signature.*	
Member Signature	Date

Mendocino County Employees' Retirement Association
625-B Kings Ct. · Ukiah, CA 95482 · (707) 463-4328 · Fax (707) 467-6472

DIRECT DEPOSIT AUTHORIZATION

I hereby authorize the Mendocino County Employees' Retirement Association to deposit all pension/annuity payments due to me from MCERA directly into the account identified below. This authority will remain in effect until I notify MCERA in writing to terminate this authorization. I understand that I must give MCERA enough notice to allow reasonable time to act on my instructions. In the event an overpayment from MCERA is credited to my account during or after my lifetime, I authorize MCERA to direct my financial institution to refund the same to MCERA and charge such payment to my account. I understand that I will not receive a check stub with automatic deposit, but can request this information by contacting MCERA.

MEMBER INFORMATION:		
Name (Last, First MI)		
Street Address		
City	State	Zip Code
Social Security Number	Birth Date	Telephone Number

FINANCIAL INSTITUTION INFORMATION:

Please Attach A Voided Blank Check. Deposit Slips Cannot Be Accepted.
(Or)
Attach Typed Confirmation Of Savings Account Number And Routing Number
From The Financial Institution. Handwritten Account Numbers Cannot Be Accepted.

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VOLUNTARY TAX WITHHOLDING REQUEST

Print Name: _____ Social Security Number: _____

I am requesting that the following amounts be held from my monthly retirement benefit.

Please specify a dollar amount for each. If you are not sure how much you may owe for your State and Federal Taxes, please contact a Tax Consultant.

Federal Tax Withholding $_____

State Tax Withholding $_____

Total $_____

OR

☐ I do not want taxes withheld from my monthly benefit.

***Please note: If approved, a service connected disability retirement is not subject to federal and state income taxes up to the 50% of final compensation. Any amount above the 50% is considered taxable.

This request for withholding may be changed at any time by completing and submitting another form. I understand that I must give MCERA enough notice to allow reasonable time to act on my instructions.

Signature: _____ Date: _____

*** You will receive a 1099R Tax Statement each tax year for any retirement benefit considered taxable. It is your responsibility to inform MCERA of any change to your mailing address.

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RETURN TO WORK ACKNOWLEDGEMENT

Government Code §7522.56 restricts a public employer's ability to reemploy a retired person, a person who (1) previously retired under the employer's pension plan, and (2) is currently receiving a benefit from that plan.

The general rule is that a retired person must be reinstated in the employer's plan upon reemployment. This means that the retired person's benefit payments under the plan would be suspended, and his or her compensation during the reemployment period would be pensionable. The retired person would receive service credit under the pension plan for the reemployment period, and the employer and retired person would have to pay required contributions to fund the corresponding benefits.

The law, however, provides that reinstatement is not required if the following conditions are satisfied:

- The employer's "appointing power" reemploys the retired person either during an emergency to prevent stoppage of public business, or because the retired person has skills needed to perform work of limited duration;
- The retired person's appointment is for no more than 960 hours per fiscal year;
- The retired person's pay rate must be within the range paid by the employer to other employees performing comparable duties (pay rate for this purpose is hourly and is determined by dividing monthly pay by 173.33, which may not make economic sense depending on the circumstances);
- The retired person must certify in writing to the employer that he or she did not, during the 12-month period preceding the reemployment date, receive unemployment insurance arising from prior employment with the reemploying employer or any other employer that maintains the same pension plan; and
- The retired person cannot be reemployed within 180 days after his or her previous employment terminated, with limited exceptions for critically needed positions, safety officers, and certain other situations.

If these conditions are satisfied, reinstatement does not apply. The retired person would continue to receive retirement benefits under the employer's plan, would not receive service credit for the reemployment period and no plan contributions on the retired person's compensation would be required.

Please be advised that while you are receiving a Disability Retirement and if you decide to seek other employment, you should contact MCERA to determine whether this employment will affect your retirement benefit.

I acknowledge that I have read and understand the above.

Signature: _____ Date: _____

Frequently Asked Questions

1. When should I file a disability application?

As soon as you are reasonably certain that your medical condition permanently prevents you from performing your usual job duties, you should file a disability application. You may apply while you are still employed or within four months following your separation from employment. You also may apply at any time from the date of discontinuance of service if you demonstrate, through medical evidence, that you have been continuously physically or mentally incapacitated from performing your job duties. You may not apply if you have withdrawn your retirement contributions.

2. May another person file a disability application for me?

Yes. Your department head or anyone else may file on your behalf, with or without your permission.

3. How is my eligibility to receive a disability retirement determined?

The Board will review pertinent medical reports and records to determine if you are permanently incapacitated. The medical reports are initially provided by you and additional medical reports may be obtained by MCERA.

4. Is workers' compensation the same thing as disability retirement?

No. MCERA and the County of Mendocino or Special Districts, which are responsible for administering workers' compensation, are separate legal entities whose actions and decisions are not binding on each other. In addition, any information provided to workers' compensation does not automatically go to MCERA. Any information pertaining to your disability retirement application/process should be sent to MCERA by you or someone on your behalf.

5. How long does this process take?

Usually 6 to 12 months from the date your application is filed. If the Retirement Board's decision is appealed, it may take longer. Each case is different, so processing times will vary.

6. Do I need an attorney to help me?

An application may be filed with or without the assistance of an attorney. If your matter goes to hearing, you may wish to obtain the services of an attorney. MCERA will be represented by an attorney. You may, however, represent yourself in any hearing or court proceeding. No other person, besides an attorney or yourself, may represent you.

7. May I receive a service retirement benefit while waiting for the Board of Retirement to decide on my application?

Yes. Whether or not you are disabled, if you are eligible to receive a regular service retirement benefit, you may file for a service retirement while you are awaiting determination of your disability application. Your retirement benefit would be adjusted, if necessary, if you are found to be permanently incapacitated by the Board.

8. Could there be any consequences if I take a service retirement benefit pending the Board's decision?

Yes. In order to receive a service retirement benefit, you must terminate your employment. If it is determined that you are not eligible for a disability retirement, you may not return to your job.

If you do not take a service retirement benefit pending the Board's decision on your disability retirement application, and it is determined that you are not permanently incapacitated, you have the right to be reinstated by your employer.

9. If my application is approved, when will my disability retirement become effective?

Your disability retirement will be effective on the date you filed your application with the Board of Retirement or the date following the last day for which you received regular compensation.

If it is determined by the Board of Retirement that you delayed in filing your application because you could not determine the permanency of your disability, or if an administrative oversight caused the delay, the effective date of your disability retirement benefit will be the date following the last day for which you received regular compensation.

You and your department payroll/personnel representative should determine if you are eligible to use your paid sick leave before receiving your disability retirement benefit.

10. When will I receive my first check?

Usually within 2 months following the Board's approval of your application.

11. How much will my disability retirement benefit be?

The amount of money you receive for a service-connected disability retirement is usually 50% of your final compensation, which is based on the average of your highest consecutive 12/36 months of salary. A service connected disability retirement is not subject to federal and state income taxes up to the 50% of final compensation. Any amount above the 50% is considered taxable.

The amount of money you receive for a nonservice-connected disability retirement is based on your years of service and a percentage of your final compensation.

The minimum benefit is 1/3 of your final compensation. This benefit will go up 2% for each additional year of service, not to exceed 40%. MCERA will furnish an estimate of benefit upon request. A nonservice-connected disability retirement benefit is subject to federal and state income taxes.

If you are eligible to receive a service retirement benefit that is greater than the service-connected or nonservice-connected disability retirement amount, you will receive the greater service retirement benefit.

12. Will my disability retirement benefit ever change?

Retired members hired before January 1, 2013will receive an annual cost-of-living adjustment (COLA) effective April 1 of each year which is paid beginning on April 30. The COLA is based on the Consumer Price Index (CPI) for the Los Angeles area and is determined annually by the Board of Retirement. The current annual maximum COLA is 3.0%. Any changes in the CPI over the maximum are held in a COLA bank and are applied to your benefit in a future year when the CPI change is less than the maximum. Members hired after January 1, 2013 do not receive an annual COLA.

13. Will I still be eligible for medical insurance benefits?

Please contact a Human Resources Benefits Specialist regarding your options.

14. May I continue to work for the County/Special District if I am found to be permanently incapacitated?

Yes. If you are capable of performing other duties, you may accept a new position with the employer. However, if the salary of your new job is less than what you earned when you became permanently incapacitated, you may ask to receive a supplemental disability benefit instead of your full disability retirement benefit. This option will need Board approval. The supplemental disability benefit you receive will generally increase your salary up to the compensation you were receiving in your old position. But, it may not be greater than the disability benefit you would have received if you had accepted a disability retirement.

If you left service due to a disability and you wish to return to work, contact MCERA for more information.

If a Safety member is found to be permanently incapacitated due to job-connection and takes a General member position, the member's Safety status will be maintained.

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