



**PUBLIC SCHOOL RETIREMENT
SYSTEM OF MISSOURI**

PO Box 268
Jefferson City, MO 65102-0268
(573) 634-5290 or
Toll Free: (800) 392-6848
Fax: (573) 634-7934
Email: psrspeers@psrspeers.org
Website: www.psr-peers.org

FILING FOR DISABILITY RETIREMENT

Qualifications for disability retirement:

- Must be incapacitated due to a physical or mental disability that appears to be total and permanent
- Must be incapable of earning a livelihood in any occupation
- Must have a minimum of five years of credit with PSRS
- Must be less than age 60
- Must be employed by an employer included in PSRS at the time the disability begins, or the disability occurs within one year after employment, and the condition causing your disability began prior to the termination of employment

Step 1

Complete and return your *Disability Retirement Application*.

Please note that the application is a three-page form. All three pages must be returned to PSRS.

The *Disability Retirement Application* should be filed as soon as you know you will be terminating your services with your employer or after the ending date of any leave of absence. Disability retirement can be made retroactive up to 60 days before the application filing date, but cannot become effective until your compensated employment or leave of absence ends.

Please note the following:

- **Last Date of Employment/Termination Date (Section B):** This means the date of your termination of employment with your employer, or if on leave of absence, the ending date of your leave, whichever is later.
- **Physician/Facility Information (Section E):** You must list the names, addresses, telephone and fax numbers for your treating physicians and medical facilities.
- **Beneficiary Designation (Section F):** You must designate beneficiaries to become effective at your retirement date.

Failure to submit all three pages of the *Disability Retirement Application* prior to the requested date of retirement will delay the effective date of retirement and cause you to lose one or more benefit payments.

Step 2

Complete and return the *Direct Deposit Authorization* form with a voided check.

Step 3

Submit a copy of your birth certificate, issued by the city, county or state of birth (unless already submitted).

Please make sure copies are readable.

Step 4

Complete and return the *Tax Withholding Authorization* form.

Contact the appropriate taxing agency or a tax specialist if you have questions about your tax liabilities or tax withholding.

Step 5

Complete and return the *\$5,000 Death Benefit Beneficiary Designation* form.

REMINDER

Purchases of credit must be paid in full prior to the effective date of your retirement. Failure to complete payment on time will cause you to lose benefits or retire without the purchased credit.



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DISABILITY RETIREMENT APPLICATION

This application *must* be filed with PSRS prior to your effective retirement date.

- Please complete and return all three pages of this application to PSRS at the address above.
- Make sure you sign the application on page 3.
- Please keep a copy for your records.
- PSRS will send an acknowledgement of your *Disability Retirement Application*.

SECTION A – MEMBER INFORMATION

First Name				Middle Name				Last Name			
Social Security Number											Member Number
Mailing Address											
City				State		ZIP		Telephone ()			
Email Address											

SECTION B – LAST PSRS-COVERED EMPLOYMENT INFORMATION

Last PSRS-covered Employer						Last Date of Employment/Termination Date					
Additional PSRS-covered Employer(s) for the Current School Year, if any						Last Date of Employment/Termination Date					
During the current school year, did you, or will you, work summer school?						<input type="checkbox"/> Yes If yes, please provide Employer name: _____ <input type="checkbox"/> No					

SECTION C – EFFECTIVE DISABILITY RETIREMENT DATE

Your effective retirement date must be *after* your last date of employment/termination date. If you earn a full year of credit with PSRS for the school year immediately before your retirement, the earliest your retirement can be effective is July 1.

I request my disability retirement be effective on: _____ **1**, _____
(month) (year)

SECTION D – DISABILITY INFORMATION

Date Disability Began: _____

(month)

(day)

(year)

Description of Disability

SECTION E – PHYSICIAN/FACILITY INFORMATION

List names, complete addresses, telephone and fax numbers of all physicians/medical facilities recently consulted.

Physician/Facility Name

Mailing Address

City

State

ZIP

Telephone

()

Fax

()

Physician/Facility Name

Mailing Address

City

State

ZIP

Telephone

()

Fax

()

Physician/Facility Name

Mailing Address

City

State

ZIP

Telephone

()

Fax

()

SECTION F – BENEFICIARY DESIGNATION

Primary Beneficiary

First Name			Middle Name				Last Name				
Social Security Number											
Date of Birth		Relationship to You									
Mailing Address											
City						State			ZIP		

First Contingent Beneficiary

First Name			Middle Name				Last Name				
Social Security Number											
Date of Birth		Relationship to You									
Mailing Address											
City						State			ZIP		

Second Contingent Beneficiary

First Name			Middle Name				Last Name				
Social Security Number											
Date of Birth		Relationship to You									
Mailing Address											
City						State			ZIP		

SECTION G – MEMBER CERTIFICATION

I understand that PSRS disability benefits may not accrue prior to the date my disability began, or prior to 60 days of filing this application. I also understand that I am no longer eligible for benefits if I recover from my disability prior to age 60. My beneficiary designation on this application becomes effective on my retirement date.

I certify that I am incapable of earning a livelihood in any occupation. I understand that prior to age 60, PSRS disability benefits will cease if I am employed in any capacity by a PSRS-covered employer. I agree that if I am less than age 60, I will provide written notice to PSRS immediately upon accepting paid employment, and my benefits will cease if I am employed outside of PSRS and have earnings that are considered a livelihood as defined by PSRS (currently \$18,000 in a 12-month period).

After reaching age 60, I may work for PSRS-covered employers up to the 550-hour and 50% compensation limits that apply to all PSRS retirees, and my work outside of PSRS is unrestricted.

I also understand that until I reach age 60, PSRS requires annual certification of my disability status, and that I may be examined by physicians designated by PSRS at such time and place as may be arranged. I expressly waive all provisions of law forbidding any physician or person who has attended or examined me, or who may hereafter attend or examine me from disclosing any knowledge or information which he or she thereby acquired.

I certify that the information given herein is true and correct.

Signature of Member X	Date
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

SECTION A – MEMBER INFORMATION

First Name				Middle Name				Last Name			
Social Security Number						Member Number				Telephone	
										()	
Mailing Address						City		State		ZIP	
Email Address											

SECTION B – PATIENT AUTHORIZATION

I hereby authorize the physician/facility below to release to the Public School Retirement System of Missouri (PSRS) any and all information acquired as a result of examination or treatment of me to be used for the purpose of determining my eligibility for disability retirement. I further waive all provisions of law forbidding release of information by an attending or examining physician.

Physician/Facility Name

Mailing Address

City

State

ZIP

Time Limit and Right to Revoke Authorization: Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the above named physician/facility. Unless revoked, this authorization will expire on the following date or event, or one year from date of signature, unless otherwise specified.

Date or Event of Expiration:

SECTION C – INFORMATION TO BE RELEASED

Information to be released covering the periods of health care for the dates below.

From (date):

To (date):

Please check type of information to be released:

<input type="checkbox"/>	Complete Health Record	<input type="checkbox"/>	Lab Test Results	<input type="checkbox"/>	Operative Report(s)	<input type="checkbox"/>	History and Physical
<input type="checkbox"/>	Consultation Report(s)	<input type="checkbox"/>	X-Ray Report(s)	<input type="checkbox"/>	Progress Note(s)	<input type="checkbox"/>	ER Report(s)
<input type="checkbox"/>	Discharge Summary	<input type="checkbox"/>	Medication(s)	<input type="checkbox"/>	Pathology Report(s)	<input type="checkbox"/>	Treatment(s)

Other (Specify)

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release: I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

Check one: Yes No

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment I agree to its release.

Check one: Yes No

SECTION D – RE-DISCLOSURE

I understand that if I authorize release of my Protected Health Information to a person or organization that is not subject to federal law governing privacy, and that person or organization re-discloses my Protected Health Information, my Protected Health Information may no longer be protected by federal privacy laws.

Signature of Member

X

Date