



NEW YORK STATE TEACHERS' RETIREMENT SYSTEM
10 Corporate Woods Drive, Albany, NY 12211-2395

APPLICATION FOR DISABILITY RETIREMENT

Social Security Number

Instructions: Write your Social Security number in the box above. Print clearly in ink or type the requested information in all white areas, and initial any change you make. Sign and notarize this application on page 2. Review the information and the checklist on page 6 before sending your application to the System. Submission of this application initiates a claim for any uncredited prior/military service and/or membership reinstatement. If you are filing for Tier 4 disability benefits, you must file an application no later than 12 months after the date that your employment status was terminated.

Effective Date of Retirement			First Name	M.I.	Last Name	Sex
Month	Day	Year				
Membership Number			Street			
Date of Birth			City	State	Zip Code	Telephone Number
Month	Day	Year	()			
Last School Year Employed			Last Teaching Location			

Annuity Savings Fund (ASF) Withdrawal (Tier 1 & 2 Members Only)	<input type="checkbox"/> Please check this box if you have an Annuity Savings Fund and wish to withdraw it. We will send you additional information and any necessary forms.
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Please approximate your salary for the current school year. This information you provide will be verified with your employer.

Contract Salary	Extra Salary for adult education, summer school, coaching or extracurricular activities	Other compensation including payment for unused leave or retirement incentive
\$	\$	\$

Were you on a leave of absence at less than full pay during the last seven years? Yes No

Are you a member of, or retired from, any other New York State public retirement system? Yes* No

*If yes, name the retirement system: _____

List below any change of address or telephone number which will occur at retirement and give the **effective date of such change**

Change of Address and/or Telephone Number	Effective Date

Do you have any unclaimed service that has not been reflected on your Benefit Profile? If so, please provide school year(s) and employer(s). It is necessary for you to provide verification of this service. Verification forms are available on our website (www.nys-trs.org):

<u>SYSTEM USE ONLY</u>
DD Received: W-4P Received: Date Application Received:

I AM APPLYING FOR DISABILITY RETIREMENT DUE TO THE FOLLOWING ILLNESS OR CONDITION (briefly describe):

If you are critically ill and wish to provide the largest lump sum payment to your beneficiary, you should elect the Declining Reserve 4% (Tier 1 members only) or the Largest Lump Sum (Tier 2, 3, 4 members) in the Benefit Election portion below.

RETIREMENT BENEFIT ELECTION

Please review the option descriptions on page 5 and **check one box below** for the form of benefit you want.

Maximum - Do **not** designate a beneficiary if you select this option.

POP-UP

*** LUMP SUM OPTIONS GUARANTEE OPTIONS SURVIVOR OPTIONS SURVIVOR OPTIONS**

Annuity Reserve (Tier 1 & 2 Only) **5 Year** **100%** **50%** **100%** **50%**

Declining Reserve 4% (Tier 1 Only) **10 Year** **75%** **25%** **75%** **25%**

Largest Lump Sum (Tier 1 members should note that the payment to a beneficiary under this option is less than the initial payment under the Declining Reserve 4%. However, this option provides the largest **fixed** lump sum payment at death.)

Alternative Option - Please provide a specific description below:

*** Please note:** The IRS is considering a change that would prevent STRS and other pension systems from offering retirement options that provide a beneficiary with a lump sum payment. **As a result, these options may not be available at retirement.**

*** Complete this section if you did not choose maximum as a benefit election ***

BENEFICIARY DESIGNATION

Beneficiary Name	Date of Birth	<input type="checkbox"/> Primary	<input type="checkbox"/> Contingent
Street	Relationship	<input type="checkbox"/> Male	<input type="checkbox"/> Female
City, State, Zip		Social Security #: <i>Required</i>	
Beneficiary Name	Date of Birth	<input type="checkbox"/> Primary	<input type="checkbox"/> Contingent
Street	Relationship	<input type="checkbox"/> Male	<input type="checkbox"/> Female
City, State, Zip		Social Security #: <i>Required</i>	
Beneficiary Name	Date of Birth	<input type="checkbox"/> Primary	<input type="checkbox"/> Contingent
Street	Relationship	<input type="checkbox"/> Male	<input type="checkbox"/> Female
City, State, Zip		Social Security #: <i>Required</i>	

➡ This application must be signed and notarized in order to be valid ⬅

Signature of Applicant	
State of New York County of _____	
On this _____ day of _____ in the year _____ before me, the undersigned, a Notary Public in and for said State, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.	
Signature of Notary: _____	Expiration Date: _____

W-4P WITHHOLDING ELECTION AND CERTIFICATE

Do not delay filing your application if you are not sure about the amount of your withholding.

STRS is required to withhold federal income tax from the taxable portion of a monthly retirement benefit that exceeds certain limits. The limit established by the IRS for 2003, for example, was \$1,300. This form should be completed if the taxable portion of your monthly benefit is in excess of the limit established by the IRS. **If you do not file a W-4P, we are required to withhold as if you were a married individual claiming three exemptions.** If the taxable part of your benefit is less than the limit, no monies will be deducted unless you elect to have a specific amount withheld.

Any election you make will remain in effect until you change it. You may change your election at any time by requesting and filing another "W-4P." If you elect not to have Federal Income Tax withheld from your monthly benefit or if you do not have sufficient Federal Income Tax withheld, you may be responsible for payment of estimated taxes. You may incur penalties under the estimated tax rules if your withholding and/or estimated tax payments are not sufficient.

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Last Name	First Name	M.I.

Social Security Number

➡ COMPLETE ONLY ONE SECTION; SIGN AND DATE BELOW ⬅

Section 1

I DO NOT want to have federal income tax withheld from my monthly benefit.

Section 2

If you want to have federal income tax withholding calculated using your marital status and the number of exemptions claimed, **COMPLETE BOTH LINES A & B** in this Section only.

A. Marital Status (*Check one*) Married Single/widow(er)

B. Total Number of Exemptions Claimed: _____

Section 3

If you wish to have a **specific dollar amount** of federal income tax withheld from your monthly benefit, please indicate the amount below.

Specific Dollar Amount to be Withheld Monthly: \$ _____

Signature:

Date:

DIRECT DEPOSIT AUTHORIZATION AGREEMENT

Please complete the information requested below and make a copy of this form for your records. ***We cannot begin your retirement payments until we receive your direct deposit agreement.***

Do not delay sending in your application if you are not sure about your direct deposit information. You will receive your payment when first eligible if the direct deposit form reaches STRS by the tenth of the month in which your benefit first becomes due.

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Last Name	First	M.I.

Social Security Number

I authorize STRS to automatically deposit any benefit payable to me in the account listed below. I understand I may cancel this authorization by submitting written notification to STRS.

I understand STRS may cease to honor this authorization or may change the terms upon notice to me. I also understand that STRS shall not be responsible for any delay resulting from inaccurate information supplied to STRS.

I understand I am entitled to my benefit payment until the date of my death. I authorize STRS to recover any overpayment from my financial institution.

Signature:	Date:

ACCOUNT INFORMATION

For a savings account, contact your bank for the information required below. If your check states it is payable through a bank different from the financial institution at which you have your checking account, do not use the ABA number on that check. Instead, contact your financial institution for the correct ABA number.

Bank Name

Account Type - Please check one
Checking <input type="checkbox"/> Savings <input type="checkbox"/>
Bank ABA/Routing # (ACH format-9 digits)
Account Number

Bank Telephone Number
()

DESCRIPTION OF MAXIMUM AND OPTIONAL BENEFITS

We must receive any change in your option election within 30 days after the date your retirement becomes effective. If you do not make an election, you will be retired under the Maximum.

MAXIMUM - Do *not* designate a beneficiary if you select this option.

This election will provide you with the largest possible annual benefit. All payments will cease at your death.

LUMP SUM OPTIONS - You may designate *multiple* primary and/or contingent beneficiaries under these options.

* **Please note:** The IRS is considering a change that would prevent STRS and other pension systems from offering retirement options that provide a beneficiary with a lump sum payment. **As a result, these options may not be available at retirement.**

Annuity Reserve - This option is *only* available to Tier 1 or Tier 2 members who do not withdraw their Annuity Savings Fund (ASF) at retirement. The Annuity Reserve is the total in your Annuity Savings Fund at retirement. If your death occurs *before* your Annuity Reserve has been paid, the balance will be paid in a lump sum to your beneficiary. If death occurs *after* your Annuity Reserve has been paid, all payments will cease at your death.

Declining Reserve 4% - This option is *only* available to Tier 1 members. The Total Reserve is the pension reserve established at the time of your retirement plus the balance in your Annuity Savings Fund, if any. If your death occurs *before* the Total Reserve has been paid, the balance will be paid in a lump sum to your beneficiary. If death occurs *after* your Total Reserve has been paid, all payments will cease at your death. There is a variation of this option based on a 7% interest rate that would result in a smaller Total Reserve but a larger monthly payment; please contact us if this interests you.

Largest Lump Sum - This option will provide all members with the *largest possible* lump sum payment to a beneficiary. Tier 1 members should note that although the payment to a beneficiary under this option will be less than the Total Reserve initially established under the Declining Reserve 4% option, the lump sum payment under this option does not decrease over time. If you desire a lesser lump sum payment to your beneficiary, you should select the Alternative Option and indicate the lump sum payment desired. **This option is *not* available to Tier 3 members retiring under Article 14.**

GUARANTEE OPTIONS - You must designate only *one* primary and may designate *multiple* contingent beneficiaries under these options.

If you predecease your beneficiary within 5 or 10 years of the date of your retirement, your beneficiary will receive the same monthly payment you were receiving for the remainder of the 5 or 10 year period. If you live beyond the 5 or 10 year guaranteed period, your benefit will cease at your death. If your primary beneficiary begins to receive payments and dies before the 5 or 10 year guaranteed period expires, the commuted value of any installments due will be paid in a lump sum to your contingent beneficiary.

SURVIVOR OPTION AND POP-UP SURVIVOR OPTIONS - You must designate only *one* beneficiary under these options.

If your beneficiary survives you, he or she will receive the designated percentage of your reduced benefit throughout his or her lifetime. You may be required to provide proof of date of birth for your beneficiary. Under the Pop-up Survivor Option your benefit will increase to the maximum if your beneficiary predeceases you. Your beneficiary designation may not be changed after 30 days from your effective retirement date. The 25% and 75% pop-up options are *not* available to Tier 3 members electing to retire under Article 14. If your spouse is your surviving beneficiary under these options, he or she will receive 50% of the COLA to which you would have been entitled had you continued to live.

ALTERNATIVE OPTION

Tier 3 members electing to retire under Article 14 may *only* request an Alternative Option that provides a survivor option of 1% to 90% at their death. All other members may request *any variation* of a lump sum guarantee, survivor or pop-up survivor option that is reasonable and can be computed actuarially.

DISABILITY RETIREMENT INFORMATION

Filing Information

If you apply for disability retirement, you must provide proof the disability existed at the time you ceased teaching in a NYS public school. The Retirement Board may require you to be examined by a physician chosen by the Board. Refusal to submit to the required examination will result in disapproval or discontinuance of your disability retirement.

In most cases your application must be received by the Retirement System ***at least 30 days*** before your date of retirement. If sent to the System by "Certified Mail" or "Registered Mail" and actually received by this System, it will be considered received on the date it was postmarked.

The 30-day filing period is waived and the option payment will be made if:

- ◆ You die before the effective date of retirement, ***and***
- ◆ You selected either the Declining Reserve 4% (if you are a Tier 1 member) or the Largest Lump Sum, ***and***
- ◆ You otherwise qualify for disability retirement, ***and***
- ◆ The Retirement Board determines the illness specified in your application related to the cause of your death.

Contributions

If you are a Tier 1 or 2 member, you may withdraw the balance of your Annuity Savings Fund (ASF), if any, in lieu of receiving a monthly annuity. To withdraw these funds, please check the box on page 1 of this application. We will deduct any outstanding loan balance from your ASF.

Cancellation or Retirement Date Change

If you wish to cancel your application for retirement or change the date your retirement will commence, you should send us a signed letter indicating your desire to cancel your retirement or change your retirement date. This letter must be received by the System ***prior to*** the date your retirement would have occurred.

Death Benefit for Tier 2, 3 and 4 Members

For those members who are eligible for the paragraph 2 death benefit coverage, a survivor's benefit may be payable to the designated beneficiary. To be eligible for this benefit, you ***must*** meet the eligibility requirements of the in-service death benefit on the day before retirement takes effect.

Membership Reinstatement

If you held an earlier date of membership in ***any*** NYS public retirement system, your current membership may be reinstated to the earlier date. **Tier 3 or 4 members reinstating to Tier 1 or 2 must repay any outstanding loan balance before their date of retirement.** If you feel you may benefit from membership reinstatement, you must advise us in writing immediately.

Accelerated Death Benefit

Under certain conditions members may be eligible to forfeit their disability retirement in lieu of a lump sum payment equal to their pre-retirement death benefit. Please advise us immediately if you are interested.

Loan Payments

If it is your intent to repay all or a portion of any outstanding loan prior to retirement, the payment ***must be*** received in this office within 30 days after the effective date of retirement. Any payments received after the date ***will not*** be credited to the outstanding loan balance.

Application Checklist

- Did you indicate your illness or condition in the box at the top of page 2?
- If you are critically ill, did you choose the appropriate option on page 2?
- If you are a Tier 1 or 2 member, did you indicate on page 1 if you wish to withdraw your annuity?
- Did you initial any changes you may have made?
- Is your retirement application signed and notarized on page 2?
- Did you sign and date the direct deposit form on page 4 and the withholding form on page 3?
- Did you include the Medical Information Summary and mail the Medical Report form(s) to your doctor(s)?
- Did you write your Social Security number in the appropriate boxes on pages 1, 3 and 4?

Please call us at 1-800-348-7298, Extension 6010 if you need help completing this application.



NEW YORK STATE TEACHERS' RETIREMENT SYSTEM
10 Corporate Woods Drive, Albany, NY 12211-2395

DISABILITY RETIREMENT INFORMATION

You and your physicians play a vital role during the processing of your application. Our Medical Board requires evidence of the extent of your disability. You have the burden of providing such evidence. We are enclosing forms that will assist you in meeting this requirement.

- **MEDICAL INFORMATION SUMMARY (RET-54.1B)** - Please complete this form and return it directly to us. **Be sure to sign the authorization.**
- **MEDICAL REPORT (RET-54.3)** - Complete Part 1 of these forms and give one to each physician involved in your care as soon as possible. **In addition to the form**, they must provide us with:
 - a comprehensive record of the history of your illness
 - copies of diagnostic test results, including x-ray, MRI and CAT scan reports
 - any surgical or pathology reports
 - a detailed narrative report of the current status of your health

Please remind your doctors of these requirements. Incomplete information will delay processing your application.

Once we receive your medical records, we will present your file at the monthly meeting of our Medical Board. If the Medical Board recommends approval, we will then present your file to the Retirement Board for consideration. The Medical Board has the authority to recommend that you be examined by a physician appointed by the System. Failure to submit to an exam will provide an independent basis to deny or discontinue benefits.

As you can see, there are many phases to the disability retirement process. Even though we will make every effort to expedite the processing of your application, delays may occur, and you should plan your finances accordingly. If you have any questions or you need additional forms, please call our Disability Unit at 1-800-348-7298, Ext. 6010.

ADDITIONAL INFORMATION FOR TIER 3 MEMBERS:

Tier 3 members may retire under Article 14 (Tier 3) or Article 15 (Tier 4) of the Retirement and Social Security Law. When we receive your application, we will review your benefits under each Article.

Benefits under Article 14 are contingent upon your receipt of primary social security disability benefits. You may file your application while that decision is pending. We cannot pay any benefits until we receive a complete copy of the *Notice of Award* **or** *Notice of Decision* issued by the Social Security Administration (SSA). Furthermore, it must be established that your disability existed when you ceased employment reportable to STRS. Your date of retirement with STRS cannot be sooner than the date of entitlement established by the SSA. If the SSA stops your payments for any reason, your benefit from STRS will also cease. **Medical records will not be needed if you only qualify for Article 14.**

Benefits under Article 15 require the recommendation of our Medical Board and approval by our Retirement Board as described above.

You will be required to make a choice if you qualify for both Articles 14 and 15.



NEW YORK STATE TEACHERS' RETIREMENT SYSTEM
 10 Corporate Woods Drive, Albany, NY 12211-2395

DESCRIPTION OF MAXIMUM AND OPTIONAL BENEFITS

The retirement benefits from this System are annual, lifetime payments to the members. At retirement you will choose either the maximum benefit or an optional benefit. The selection can only be made at the time of retirement and cannot be changed after the end of the month in which you retire.

Maximum

This election will provide you with the largest possible annual benefit. The maximum benefit does not provide a payment to a beneficiary. All payments will cease at your death.

Lump Sum Options — You may designate **multiple** primary and/or contingent beneficiaries under these options.

Annuity Reserve — This option is **only** available to Tier 1 or Tier 2 members who do not withdraw their Annuity Savings Fund (ASF) at retirement. The Annuity Reserve is the total in your ASF at retirement. If your death occurs **before** the Total Reserve has been paid, the balance will be paid in a lump sum to your beneficiary. If death occurs **after** the Annuity Reserve has been paid, all payments will cease at your death.

Declining Reserve 4% — This option is **only** available to Tier 1 members. The Total Reserve is the pension reserve established at the time of your retirement plus the balance in your Annuity Savings Fund, if any. If your death occurs **before** the Total Reserve has been paid, the balance will be paid in a lump sum to your beneficiary. If death occurs **after** the Total Reserve has been paid, all payments will cease at your death. There is a variation of this option based on a 7% interest rate that would result in a smaller Total Reserve but a larger monthly payment; please contact us if this interests you.

Largest Lump Sum — This option will provide all members with the **largest possible** lump sum payment to a beneficiary. Tier 1 members should note that although the payment to a beneficiary under this option will be less than the Total Reserve initially established under the Declining Reserve 4% option, the lump sum payment under this option does not decrease over time. **This option is not available to Tier 3 members retiring under Article 14.**

Your estimate provides you with the largest lump sum payment to your beneficiary. The "Cost per \$1000" indicated on your estimate will allow you to calculate your benefit should you desire a fixed lump sum payment of a lesser amount to your beneficiary. If you desire a lesser lump sum payment to your beneficiary, you should select the Alternative Option on the retirement application and indicate the lump sum payment desired. The following example will help you calculate the effect a lesser lump sum payment will have on your retirement benefit.

Example: Your Annual Maximum Benefit is \$60,000; your "Cost per \$1000" is \$25; you want to provide a \$20,000 lump sum payment to your beneficiary.

20 (increments of \$1000 needed) x \$25 ("Cost per \$1000") = \$500 Annual Cost of the Coverage

\$60,000 (Maximum Benefit) minus \$500 (Cost of Coverage) = \$59,500 Optional Member Benefit

Guarantee Options — You may designate **one** primary and **multiple** contingent beneficiaries under these options.

If you predecease your beneficiary within 5 or 10 years of the date of your retirement, your beneficiary will receive the same monthly payment you were receiving for the remainder of the 5 or 10 year period. If you live beyond the 5 or 10 year guaranteed period, your benefit will cease at your death. **If your primary beneficiary begins to receive payments and dies before the 5 or 10 year guaranteed period expires, the commuted value of any installments due will be paid in a lump sum to your contingent beneficiary.**

Survivor Option and Pop-up — You may designate only **one** beneficiary under these options.

If your beneficiary survives you, he or she will receive the designated percentage of your reduced benefit throughout his or her lifetime. You must provide proof of date of birth for your beneficiary. **Under the Pop-up Option your benefit will increase to the maximum if your beneficiary predeceases you. Your beneficiary designation may not be changed after the month retirement occurs. The 25% and 75% pop-up options are not available to Tier 3 members electing to retire under Article 14.**

Alternative Option

Tier 3 members electing to retire under Article 14 may only request an Alternative Option that provides a survivor option of 1% to 90% at their death. All other members may request any variation of a lump sum, guarantee, survivor or pop-up option that is reasonable and can be computed actuarially.

Beneficiaries of Tier 2, 3, or 4 members who elected the **In-Service Paragraph 2 Death Benefit** upon joining NYSTRS may be entitled to receive a **lump sum payment** after retirement. The lump sum payment would be in addition to any payments made as a result of an Optional Benefit selection. Please refer to A *Member's Handbook* and your *Benefit Profile* for additional information.



NEW YORK STATE TEACHERS' RETIREMENT SYSTEM
10 Corporate Woods Drive, Albany New York 12211-2395

MEDICAL INFORMATION SUMMARY

COMPLETE AND RETURN WITH YOUR RETIREMENT APPLICATION

A U T H O R I Z A T I O N

I hereby authorize and direct any physician, hospital, medical records facility or any other party to disclose to the New York State Teachers' Retirement System all information which they may possess including, but not limited to, diagnosis, treatments rendered, x-rays and copies of all hospital and medical records which are in their possession, and further, I waive any claim of privilege in respect thereto. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Applicant: _____

IMPORTANT: The authorization above must be signed

- A. Please list the names, addresses and telephone numbers of the physicians consulted in connection with your illness from whom we should expect a report*:

Names and Addresses	Telephone and FAX Numbers

****It is your responsibility to give a medical report form to each of the physicians named***

- B. Briefly describe your illness and symptoms (If more room is needed, please use reverse side)

C. On what date did you become incapacitated? _____

D. What was the last date you rendered service? _____

E. What subject area and grade level was your last teaching position? _____

- F. Do you work in any other capacity? No Yes
If yes, please explain. _____



NEW YORK STATE TEACHERS' RETIREMENT SYSTEM
10 Corporate Woods Drive, Albany, NY 12211-2395
1-800-348-7298, Ext. 6010; Fax 518-447-2815

MEDICAL REPORT

PART 1 (To Member): This section must be completed by you and forwarded to your physician

Patient Name and Address		EmplID or Social Security Number	Date of Birth
Physician Name		Physician Address	
<p>I hereby authorize and direct any physician, hospital, medical records facility or any other party to disclose to the New York State Teachers' Retirement System all information which they may possess including, but not limited to, diagnosis, treatments rendered, x-rays, and copies of all hospital and medical records which are in their possession, and further, I waive any claim of privilege in respect thereto. A photocopy of this authorization shall be considered as effective and valid as the original.</p> <p>Signature of Applicant: _____</p>			

PART 2 (To Physician): Your patient applied for disability retirement from this System. *Benefits will not be granted until we receive complete documentation of the person's illness.*

Please provide all of the following:

- ◆ **Answers to the questions listed below.**
- ◆ **A narrative description of the person's illness (the reverse side of this form is provided for this purpose).**
- ◆ **Copies of any pathological and x-ray reports, CAT scans, MRI's, operation notes, psychological and neurological evaluations and any previously prepared reports that clearly outline the history of the person's illness.**

Date you first treated this patient:	_____
Date the disability began:	_____
Date you last saw this patient:	_____
Is this patient totally and permanently disabled for performing the duties of a teacher?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please explain why: _____	

Is this patient totally and permanently disabled for performance of gainful employment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please explain why: _____	

Physician's Signature:	_____ Date: _____
Specialty, if any:	_____ Date of Board Certification: _____

**** SEE REVERSE SIDE ****

PART 3 (To Physician): Provide a narrative description of the person's illness including:

- ◆ a history
- ◆ treatment received and the result
- ◆ diagnosis
- ◆ prognosis

Please type or print clearly

Physician's Signature: _____

Specialty, if any: _____ Date of Board Certification: _____



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Patient Name and Address		EmplID or Social Security Number	Date of Birth
Physician Name		Physician Address	
<p>I hereby authorize and direct any physician, hospital, medical records facility or any other party to disclose to the New York State Teachers' Retirement System all information which they may possess including, but not limited to, diagnosis, treatments rendered, x-rays, and copies of all hospital and medical records which are in their possession, and further, I waive any claim of privilege in respect thereto. A photocopy of this authorization shall be considered as effective and valid as the original.</p> <p>Signature of Applicant: _____</p>			

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Date you first treated this patient:	_____
Date the disability began:	_____
Date you last saw this patient:	_____
Is this patient totally and permanently disabled for performing the duties of a teacher?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please explain why: _____	

Is this patient totally and permanently disabled for performance of gainful employment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please explain why: _____	

Physician's Signature: _____	Date: _____
Specialty, if any: _____	Date of Board Certification: _____

**** SEE REVERSE SIDE ****

PART 3 (To Physician): Provide a narrative description of the person's illness including:

- ◆ a history
- ◆ treatment received and the result
- ◆ diagnosis
- ◆ prognosis

Please type or print clearly

Physician's Signature: _____

Specialty, if any: _____ Date of Board Certification: _____



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Patient Name and Address	EmplID or Social Security Number	Date of Birth
Physician Name	Physician Address	
<p>I hereby authorize and direct any physician, hospital, medical records facility or any other party to disclose to the New York State Teachers' Retirement System all information which they may possess including, but not limited to, diagnosis, treatments rendered, x-rays, and copies of all hospital and medical records which are in their possession, and further, I waive any claim of privilege in respect thereto. A photocopy of this authorization shall be considered as effective and valid as the original.</p> <p>Signature of Applicant: _____</p>		

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Please provide all of the following:

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- ◆ **A narrative description of the person's illness (the reverse side of this form is provided for this purpose).**
- ◆ **Copies of any pathological and x-ray reports, CAT scans, MRI's, operation notes, psychological and neurological evaluations and any previously prepared reports that clearly outline the history of the person's illness.**

Date you first treated this patient:	_____
Date the disability began:	_____
Date you last saw this patient:	_____
<p>Is this patient totally and permanently disabled for performing the duties of a teacher? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please explain why: _____</p> <p>_____</p>	
<p>Is this patient totally and permanently disabled for performance of gainful employment? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please explain why: _____</p> <p>_____</p>	
<p>Physician's Signature: _____ Date: _____</p>	
Specialty, if any: _____	Date of Board Certification: _____

**** SEE REVERSE SIDE ****

PART 3 (To Physician): Provide a narrative description of the person's illness including:

- ◆ a history
- ◆ treatment received and the result
- ◆ diagnosis
- ◆ prognosis

Please type or print clearly

Physician's Signature: _____

Specialty, if any: _____ Date of Board Certification: _____