

APPLICATION FOR DISABILITY RETIREMENT

READ INSTRUCTIONS CAREFULLY ON PAGE 2 BEFORE COMPLETING.		
Please type or print. Send completed application to address above. Application processing will be delayed until all requested information is provided.		
Name (Last, First, Middle)	Social Security No. <small>(last 4 digits only) -</small>	Date of Birth (MM,DD,YY)
Street Address	City, State, Zip Code	Home Phone No.
Tribe Name		Tribal Code
In what capacity do you make this application? (Check box) <input type="checkbox"/> Member <input type="checkbox"/> Employer	Type of Disability (Check Box) <input type="checkbox"/> Duty <input type="checkbox"/> Non-duty	
What is the nature of the disability? Explain in detail. Use additional sheets if necessary.		
How was the disability caused? Explain fully. Use additional sheets if necessary.		
Have you applied for worker's compensation benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you applied for social security benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If the answer(s) is yes, please send evidence of the actual amount of the benefits you are receiving. If the answer(s) is no, you must immediately notify TGRS-MERS if you apply for worker's compensation and/or social security benefits at a later date.		
Signature of Applicant		Date
MUST BE COMPLETED BY THE EMPLOYER TRIBE		
I certify that the above-named employee <input type="checkbox"/> is <input type="checkbox"/> is not receiving worker's compensation benefits and <input type="checkbox"/> was <input type="checkbox"/> will be separated from the payroll of this tribe on _____. <div style="text-align: right;"><small>(MM/DD/YY)</small></div> NOTE: If your tribe provides a wage continuation plan (which includes short- and/or long-term disability) please indicate here the weekly amounts paid this member with the beginning and ending dates of payment.		
Weekly Amount	From	To
Signature of Payroll Official		Date of Signature

If you have speech or hearing difficulties and need assistance completing this form, contact the Michigan Relay Center at 1-800-649-3777. If you have other disabilities, contact TGRS-MERS at 1-877-641-8477 to request special accommodations.

RETURN TO: Tribal Government Retirement System c/o TGRS-MERS
 1134 Municipal Way
 Lansing, MI 48917
 Phone: (877) 641-8477 • Fax: (517) 703-9706

INSTRUCTIONS

1. Complete the top portion of page 1 and return the application to your payroll office. The payroll office will complete the employer portion of the application and forward it to TGRS-MERS.
2. Enclose the following documents with your application:
 - a. A Physician's Statement completed by your treating physician (You must sign the release of medical information consent clause on page 4 of the statement);
 - b. Either a second Physician's Statement completed by another physician from a different medical practice, or a Psychiatric Medical Report if you are claiming a psychiatric disability (completed by your treating psychiatrist or psychologist);
 - c. A complete medical record, including copies of all doctors' reports, diagnostic tests, surgery and hospitalization reports, medications, treatment plans, etc., relevant to your application;
 - d. A copy of the Employer's official position description for the job that you performed;
 - e. A copy of any disability determination by the Social Security Administration, including benefits and payment dates; and,
 - f. A copy of your birth certificate. If your current name is different than the last name on your birth certificate, please provide a copy of marriage certificate or court order changing name.
3. Enclose the following additional documents if you are claiming a duty-related disability:
 - a. A copy of the Employee's Basic Report of Injury filed with the Bureau of Worker's Compensation;
 - b. A statement of any weekly worker's compensation that is (or was) being paid as a result of the work-related injury/disease, including benefits and payment dates; and
 - c. All documents relating to the payment of worker's compensation, including redemption orders and/or hearing or mediation proceedings before the Bureau of Worker's Compensation.

GENERAL PROVISIONS OF MERS PLAN DOCUMENT

1. Disability retirees may be required to be examined by a physician annually, or at least once every five years, depending on the recommendation of TGRS-MERS' medical advisor.
2. The MERS Plan Document places a limitation on the amount of disability benefits payable between the effective date of retirement and age 60. The limitation applies to the amount of disability benefits allowed under straight life before the election of any other form of payment.
3. Disability benefits received from TGRS-MERS when added to other income sources received by the retiree are limited to 100% of the member's final average compensation. The other sources include:
 - a. Remuneration from gainful employment. This also includes self-employment that results in a profit.
 - b. Worker's compensation weekly benefits, redemption, and settlements on account of the same disability.
 - c. Payments made under a salary continuance plan, sickness and accident insurance, disability insurance, or program of similar purpose, financed in whole or in part by the participating municipality.
 - d. Social Security benefits paid to the retiree.
4. Cost-of-living increases in worker's compensation and Social Security benefits are disregarded for purposes of the limitation.
5. If the disability retiree cannot provide the amount of worker's compensation and/or Social Security benefits being received, the amount will be determined on the basis of the retiree's final average compensation and the single person statutory benefits.
6. Upon receipt of evidence of the actual amount of worker's compensation and/or Social Security benefits being received, TGRS-MERS will adjust the amount of retirement allowance being paid and recover any overpayment that may have occurred. Overpayments may be recovered by full repayment or by recouping the immediate overpayments from future retirement allowances.