MACRS

Review of PERAC Forms

DISABILITY FORMS
BENEFICIARY FORMS

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New Disability Forms

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PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction
Member's Application for Disability Retirement

Form Last Revised: October 2018

Before you file an application for a disability retirement allowance, please note that you should:

- Contact your retirement board. This is an important step in ensuring that you have all of the information that you need. The staff at your retirement board will help you understand the process and respond to your questions throughout the process.

Read the *Guide to Disability Retirement for Public Employees*

- *www.mass.gov/perac*
- This guide will give you general information about the disability process. Your retirement board can furnish you with a copy of this guide.

Next Step

- Be sure to complete the entire application, including the release forms, and attach all required documents before returning your application to your retirement board. If your application is incomplete, the
application process will be delayed. Until all of the required information has been submitted, your retirement board cannot assign a date of application, which will be very important in determining your effective date of retirement and retirement allowance date.
- Your retirement board can prepare an estimate of your retirement allowance for planning purposes at any time, but an official retirement allowance cannot be calculated until your application has been approved. If your application is approved, you may need to submit additional documents, including, if applicable, your marriage certificate, your spouse's birth certificate, and your dependent children's birth certificates.
- Before you send your application and your documents to your retirement board, make a photocopy of them for your own records.

Your Retirement Board Will:

- Request information from your employer, your personal physician, and the other physicians, hospitals, and insurance companies that you identified on your application.
- You may, if you wish, submit the Treating Physician's Statement to your primary treating physician. If you choose to do so, let your retirement board know so that duplication of effort can be avoided.

Next Step

- When all the information specified above has been received by your retirement board, the application package is considered complete and your retirement board will decide whether to ask the Public Employee Retirement Administration Commission (PERAC) to set up a three member regional medical panel to examine you.

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction
Member's Application for Disability Retirement (continued)

Form Last Revised: October 2018 **2**

Timeframes

- The regional medical panel should meet within 60 days of being appointed by PERAC to conduct its examination.
- You will be given a 14 day notice of the scheduled examination.
- The regional medical panel will report their findings and recommendations to PERAC within 60 days after completing their examination(s).
- Within 5 days of receipt of a properly completed medical panel report, PERAC will forward the report to your retirement board.
- Your retirement board has the option at this point of requesting further information or a clarification from the regional medical panel if they determine that it would be helpful.
- Within 30 days of receipt of the report, your retirement board will notify you of the panel's findings and provide you with a copy of all of the documents completed by the regional medical panel.
- If the regional medical panel precludes retirement for the disability you claimed, your retirement board could either deny your application or it could ask PERAC for a new regional medical panel if the board believes that circumstances warrant it.

  If PERAC declines to schedule a new examination, your board will deny your application.
- If the regional medical panel findings permit retirement for the disability claimed, your retirement board shall determine whether or not to approve the application.
- A hearing may be held on any disability retirement application and shall be held upon your request.
- If a hearing is scheduled, your board must give you at least a 30 day notice of the time and place for the hearing and the issues involved.
- Your retirement board's decision about your eligibility for disability retirement must be made no later than 180 days after you file your completed application, unless PERAC grants an extension.
- If your application is approved by your retirement board, it will be transmitted to PERAC for final action. PERAC must act on your application within 30 days of its receipt.
- If your application is denied by your retirement board, your retirement board will advise you of your right to appeal the decision.

Member's Application for Disability Retirement

Form Last Revised: October 2018 3

RETIREMENT BOARD: Please enter your retirement board information here.

Name of Retirement Board:

Address:

City/Town: **Zip:**

Applicant's Information

Applicant's Last Name | **First Name** | **M.I.** | **Former or Maiden Name** (if different)

Street Address | **Social Security # (last four)**

City/Town | **State** | **Zip** | **Phone #**

Email Address

Date of Birth | **Place of Birth**

Sex ☐ **M** ☐ **F** **Are You a Veteran?** ☐ **YES** ☐ **NO**

If you will be residing at an address other than the one above (for example, a summer or retirement address) within the next 12 months, please list your alternate address below.

Alternate Street Address

City/Town | **State** | **Zip** | **Phone #**

To: **From:**

Dates in Residence at Alternate Address (Fill in To/From Above)

I understand that I have the right to apply for Accidental Disability and/or Ordinary Disability Retirement benefits. If I believe my disability may be the result of a job-related incident or injury, I may apply for Accidental Disability benefits and must answer all of the questions on this application. I will be required to provide evidence that my disability occurred as a result of a personal injury sustained or a hazard undergone while in the performance of my duties at a definite place and time without serious and willful misconduct on my part.

If I apply for Accidental Disability Retirement and PERAC approves my application after considering the Retirement Board's findings, the Regional Medical Panel Report and other evidence, I will be granted an Accidental Disability.

If I apply for an Accidental Disability and PERAC approves an Ordinary Disability application for me based on the Retirement Board's findings, the Regional Medical Panel Report and other evidence, then I may be retired for Ordinary Disability.

I apply to be retired on the basis of (Please check one):

☐ ACCIDENTAL DISABILITY ☐ ORDINARY DISABILITY ☐ EITHER ACCIDENTAL or ORDINARY DISABILITY

I sign this application under the penalties of perjury. I affirm that the information presented in this application is correct, complete and accurately presented. I understand that giving false or incomplete information on this application may subject me to loss of my benefits as well as civil and criminal penalties.

Applicant's Signature: **Date:**

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Statement of Applicant's Duties

In order to receive a disability retirement allowance, a member must be permanently and totally disabled from performing the essential duties of his/her position. Essential duties are those duties or functions of a job or position that must necessarily be performed by an employee to accomplish the principal object(s) of the job or position. In accordance with PERAC's regulations, 840 CMR 10.07, your employer is required to identify the essential duties of your position.

1. Please state the medical condition(s) for which you are filing this application for disability retirement.

2. What is your current position and job title?

3. Is this a temporary or accommodated position?

4. Please describe the duties that you are required to perform in your current position.

5. How frequently are you required to perform these duties?

6. Please describe the duties that you are unable to perform as a result of your disability.

7. When did you cease to be able to perform all of the essential duties of your current position?

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Member's Application for Disability Retirement

Disability Type: ______ **Member:** ______ **SSN:** ***-**-__ __ __ __

Your Employment History

Your Current Position (From which you plan to retire)

Title	**Name of Department**		
Employer's Street Address			**Name of Head of Department**
City/Town	**State**	**Zip**	**Employer's Email Address**
Phone #	**Fax #**		**From:** **To:** **Dates Employed** (Fill in From/To above)

Your Previous Positions

Please list all previous employment, beginning with your most recent position. Include all prior public and private employment. Please note that, if any other Massachusetts agency or unit has ever employed you, you may be eligible to purchase creditable service for that public sector employment. Contact your retirement board for further information about making such a purchase. If you need additional space, please attach a separate sheet.

Employer's Name	**From:** **To:** **Dates Employed** (Fill in From/To above)		
Street Address	**City/Town**	**State**	**Zip**
Employer's Name	**From:** **To:** **Dates Employed** (Fill in From/To above)		
Street Address	**City/Town**	**State**	**Zip**
Employer's Name	**From:** **To:** **Dates Employed** (Fill in From/To above)		
Street Address	**City/Town**	**State**	**Zip**
Employer's Name	**From:** **To:** **Dates Employed** (Fill in From/To above)		
Street Address	**City/Town**	**State**	**Zip**
Employer's Name	**From:** **To:** **Dates Employed** (Fill in From/To above)		
Street Address	**City/Town**	**State**	**Zip**

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Statement About Recent Physical Activities

1. For the period of the last year, please describe your physical activities, including:
   - Medical rehabilitation activities
   - Activities of daily living (for example, driving, cleaning, etc.)
   - Sports or other strenuous activities
   - Other employment since the onset of your disability

G.L. c. 32, § 15

1. Have you been officially investigated for or charged with misappropriation of funds from your employer or convicted of any crime related to your office or position? **YES** **NO**
   If **YES**, please provide documentation.

If you are applying for ordinary disability, you are not required to complete the section for accidental disability.

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Reason for Accidental Disability

One of the conditions for receiving approval of an application for accidental disability retirement is that your retirement board must find that your disability is the natural and proximate result of either a personal injury you sustained (usually, one or several specific incidents), or a hazard undergone (generally, exposure to a harmful situation over a period of time).

Please identify the reason for your disability: **Personal Injury** **Hazard**

In describing the personal injury that you sustained or the hazard to which you were exposed, it is important to be as specific as possible.

Medical Condition

1. Date(s):
2. Specific time(s) or if hazard, length of time exposed:
3. Location(s):
4. Description of incident(s) or hazard:
5. Job duties you were performing at the time of the incident:
6. In your own words, what is the injury(s) sustained as a result of the described incident?

Other Conditions

1. Please describe any other circumstances, events, or physical conditions that contributed or may have contributed to your disability.

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Incident Reports

Please provide the following information ***about each person or agency*** with which you filed a report of the injury(ies) that you sustained or the hazard to which you were exposed.

Agency		Name (First, Last, Middle)	
Street Address		City	State / Zip
Phone #	Fax #	Email	Date You Filed Report
Agency		Name (First, Last, Middle)	
Street Address		City	State / Zip
Phone #	Fax #	Email	Date You Filed Report

(Attach additional sheets if necessary)

Witness Data:

For each witness to the incident(s) or hazard(s) that you've described, please provide the following information.

Name (First, Last, Middle)	Phone #	Relationship to You	
Street Address	City	State	Zip
Name (First, Last, Middle)	Phone #	Relationship to You	
Street Address	City	State	Zip

(Attach additional sheets if necessary)

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Other Actions Taken

As a result of the incident(s) or hazard(s) that you have described, have you filed a grievance pursuant to a collective bargaining agreement? **YES** **NO**
If **"YES"**, please describe the status of your grievance.

Did your employer take any administrative or disciplinary action as a result of the incident(s) or hazard(s) you have described? **YES** **NO** If "**YES"**, please describe the current status of this action.

Is there now or has there been, any other litigation in any forum regarding the injury upon which this application is based? **YES** **NO** If **"YES"**, please describe current the status of your litigation.

Workers' Compensation

Have you applied for, or are you receiving, or have you received weekly Workers' Compensation benefits or a Workers' Compensation settlement related to your claimed disability? **YES** **NO**
If **"YES"**, please describe the current status of your Workers' Compensation.

Section 111F Benefits

Have you received or are you receiving benefits, related to your claimed disability, pursuant to G.L. c. 41, § 111F? **YES** **NO** If **"YES"**, please describe the current status of your Section 111F Benefit.

Other Payments

Have you received any other payments, assault, injury, etc. as a result of the injury upon which this application is based?
YES **NO** If **"YES"**, please describe the current status of these payments.

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Medical Treatment - Treating Physician

Your retirement board will request a statement certifying your disability status from the physician who is treating you for your disability. Please provide the following information about the physician who has provided you with treatment in connection with your disability.

Health Care Provider's Name		**Hospital/Facility**	
Street Address	**City**	**State**	**Zip**
Phone #	**Fax #**	**Email**	
From:		**To:**	

Dates of Treatment (Fill in From/To above)

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Physicians, Hospitals and Medical Facilities

Please list all physicians, hospitals and medical facilities with which you have consulted for your claimed disability. In addition, please list any physicians, hospitals and medical facilities at which you have received any treatment for any other condition within the last five years.

Begin with your Emergency Room/Facility treatment regarding the injury claimed as the basis of your disability, followed by the most recent hospital or medical facility from which you sought a consultation or treatment.

If you need more space, you may attach additional sheets.

Name of Emergency Room/Facility

Facility Street Address | **City** | **State** | **Zip**

Phone # | **Fax #** | **Email**

From: | **To:**

Reason for Visit | **Dates of Treatment** (Fill in From/To above)

Name of Physician or Facility

Facility Street Address | **City** | **State** | **Zip**

Phone # | **Fax #** | **Email**

From: | **To:**

Reason for Visit | **Dates of Treatment** (Fill in From/To above)

Name of Physician or Facility

Facility Street Address | **City** | **State** | **Zip**

Phone # | **Fax #** | **Email**

From: | **To:**

Reason for Visit | **Dates of Treatment** (Fill in From/To above)

Name of Physician or Facility

Facility Street Address | **City** | **State** | **Zip**

Phone # | **Fax #** | **Email**

From: | **To:**

Reason for Visit | **Dates of Treatment** (Fill in From/To above)

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Attorney Information

If you are represented by an attorney in this disability retirement application process, please provide the following information so that we may contact him or her as necessary.

Name of Attorney		Name of Firm	
Street Address	**City**	**State**	**Zip**
Phone # / **Fax #**	**Email**		

Insurance Coverage

If you have any insurance that covers the incident(s) or hazard(s) that you have described, please provide the following information about each policy.

Name of Insurance Company		Policy # *(if known)*	
Insurance Co. Street Address	**City**	**State**	**Zip**
Phone # / **Fax #**	**Email**	**Type of Coverage**	

Name of Insurance Company		Policy # *(if known)*	
Insurance Co. Street Address	**City**	**State**	**Zip**
Phone # / **Fax #**	**Email**	**Type of Coverage**	

Member's Application for Disability Retirement

Form Last Revised: October 2018 **13**

The following authorization and selection forms are attached to your application. Make sure that you complete each of these forms and return them to your retirement board along with the rest of your completed application:

- Your signed *Authorization for Release of Medical and Insurance Records*
- Your signed *Authorization for Release of Tax Records*
- Your signed *Regional Medical Panel Selection Form*

If your application is approved, you may need to submit additional documents, including, if applicable:

- Your marriage certificate
- Your spouse's birth certificate
- Your dependent children's birth certificates
- Your birth certificate (or proof of age)
- Your military form DD214, if applicable to your personal situation

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Authorization to Use or Disclose Protected Health Information

I hereby authorize:

(physician, hospital, insurance company, employer, other health/rehabilitation entity)

to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to Federal or State law protecting its confidentiality. Information released on this authorization, if redisclosed by the recipient, is no longer protected.

Patient Name **Date of Birth**

Street Address **City** **State** **Zip**

Information To Be Disclosed To (Please check one): ☐ **PERAC**

☐ **Retirement Board** (Enter address below)

Address:

City/Town: **State:** **Zip:**

Please check the box below to authorize release of your complete medical record, or, use the lines below to stipulate any exceptions.

☐ Authorize Release of Complete Medical Record

Exceptions:

This form encompasses the following:

- Disability Retirement Application: (G.L. c. 32, §§ 6, 7, 26, 94, 94A and 94B)
- Restoration to Service Evaluation (including rehabilitation): (G.L. c. 32, §§ 8 and 26)
- Accidental Death Benefit: (G.L. c. 32, §§ 9 and100)

I understand I may revoke this authorization at any time by notifying the Retirement Board in writing, unless action has already been taken in reliance upon this authorization, or during an appeal under the applicable law.

This authorization will expire upon final determination of my disability application and Comprehensive Medical Evaluation/ Rehabilitation/Restoration to Service process.

Printed Name of Patient or Patient's Rep.: **Date**

Signature of Patient or Legal Representative:

Relationship to Patient/ Authority to Act for Patient, if applicable:

Member's Application for Disability Retirement

Form Last Revised: October 2018

About the Authorization to Use or Disclose Protected Health Information

All entries must be completed for this authorization to be valid.

Please note, Retirement Boards are not covered entities under the Health Insurance Portability and Accountability Act (HIPAA), however all information is treated in a confidential manner consistent with Federal and State privacy laws.

How This Information is To Be Used

Pursuant to Massachusetts General Laws, Chapter 32, Sections 6, 7, 26, 94, 94A and 94B, the Public Employee Retirement Administration Commission (PERAC) is responsible for appointing regional medical panels to evaluate members seeking Disability Retirement. During the application process the Retirement Board and PERAC may obtain, share, and disclose information as necessary to complete the Disability Retirement process.

Pursuant to Massachusetts General Laws, Chapter 32, Sections 8 and 26, PERAC is also responsible for conducting Comprehensive Medical Evaluations (CMEs), offering Rehabilitation, and scheduling Restoration to Service (RTS) examinations to determine if the member is able to perform the essential duties of his/her former position, with or without rehabilitation. During this process, the Retirement Board and PERAC may obtain, share, and disclose information as necessary to complete this evaluation process. The information used/shared/disclosed during the four phases of the Disability process may include information provided by physicians, hospitals, insurance companies, employer, and other health/rehabilitation entities.

Please note, this original authorization form may be copied and reissued for the purpose of gathering and sharing protected information necessary to the Disability Application, CME, Rehabilitation, and RTS examinations.

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Medical Panel Selection

Unless your retirement board denies your application as a result of an initial fact-finding hearing, you must have a regional medical panel examination. PERAC appoints all regional medical panels. When your retirement board determines that your application for disability retirement is complete, the board (which meets at least once each month) may petition PERAC to appoint a three-member state-financed independent regional medical panel to examine you.

No physician who has already examined you or treated you, except as part of a prior regional medical panel, can be appointed to a panel to examine you.

PERAC will schedule the regional medical panel examination(s) and notify you at least 14 days in advance of the date(s), time(s), and location(s).

Regional Medical Panel Selection Form

Three Separate Single Examinations or One Joint Examination

- You have the right to request three separate single physician examinations when you file your disability application.
- If you do not request separate single examinations at application filing time a join panel can be convened.
- You may request separate examinations at any time prior to a joint examination date, but PERAC will not ordinarily consider requests for separate examinations less than 48 hours prior to a scheduled joint examination.

You must indicate whether you prefer one joint examination or three separate single examinations by checking one of the boxes below:

☐ I want to be examined by a joint regional medical panel.

☐ I want to be scheduled for three separate single examinations.

By signing, I acknowledge that if I fail to appear at the scheduled medical appointment(s), I will be required to reimburse the Commonwealth for the cost of the examination, prior to the scheduling of a new examination.

Signature of Applicant: **Date:**

Unless your retirement board denies your application, at this point, you must have a regional medical panel examination. PERAC appoints all regional medical panels.

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Member's Application for Disability Retirement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Addendum Sheet to the Member's Application for Disability Retirement

Please use this sheet to provide further information in the event that you find the space provided on the form to be insufficient. Please identify the question(s), by Page Number and Question Number, for which you are providing further information.

Member's Application for Disability Retirement

Form Last Revised: October 2018 **18**

Applicant's Authorization for Release of Tax Records

This will certify that I authorize release of information from the federal Internal Revenue Service and the Massachusetts Department of Revenue relative to my annual gross earned income pursuant to any agreement between the federal Internal Revenue Service, the Massachusetts Department of Revenue and the Public Employee Retirement Administration Commission.

I understand that G.L. c. 32, §§ 6, 7, 8, 26, 94, 94A, 94B, 91 and 91A require this authorization and my failure to provide this release may result in the denial, suspension and/or termination of my benefits.

Applicant's Last Name	**First Name**	**M.I.**	**Former or Maiden Name** (if different)
Street Address			**Social Security #**
City/Town	**State**	**Zip**	**Phone #**
Email Address			
Signature			**Date**

THIS PAGE OF THE FORM IS NOT TO BE SUBMITTED TO PHYSICIANS

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Employer's Statement Pertaining to an Application for Disability Retirement

Updated October, 2018

Who should prepare this form?

In accordance with 840 CMR 10.07 (Code of Massachusetts Regulations), the *Employer's Statement* should be prepared by the head of the department that employs the disability retiree applicant. However, if the department head does not supervise the applicant, the applicant's direct supervisor should prepare and sign this statement and it should be counter-signed by the department head.

What is the timeframe associated with this form?

The *Employer's Statement* should be completed and filed with the applicant's retirement board within fifteen days of its being received by the employer.

Who will ask the employer to complete this form?

In the retirement application that an applicant submits to his/her retirement board, the applicant will identify the name and address of his/her department head and his/her direct supervisor.

The retirement board will send a copy of the *Employer's Statement* to the applicant's department head and request that the form be completed, regardless of whether this is a voluntary or involunary application.

If an employer has questions about this form, who should be contacted?

If an employer needs further explanation about this form or the disability process in general, the employer should contact the member's retirement board *(see next page for contact information)*.

What documents must the employer attach to the *Employer's Statement*?

- A copy of the applicant's current official job description. In that job description, the employer must designate those duties that are essential. Employers should use the "Determination of Essential Duties" section of the *Employer's Statement* as a guideline.
- Copies of any and all records regarding the applicant's physical condition at the time of his or her employment with the department (for example, a pre-employment physical examination).
- Copies of any and all records regarding the applicant's physical condition after he or she was employed by the department.
- Copies of all reports or investigations concerning the applicant's incidents or hazards.
- Copies of any and all Workers' Compensation incident reports and/or any Workers' Compensation settlement agreements made on behalf of the applicant.
- Copies of any and all reports associated with the applicant's G.L. c. 41, § 111F benefits.

- Form last updated: 9/17/18

Employer's Statement Pertaining to an Application for Disability Retirement

Updated October, 2018 2

Please return to the Applicant's Retirement Board:

Name of Retirement Board:			
Address:			
City/Town:		**Zip Code:**	
Telephone:		**Fax:**	
Email:			

Disability Applicant Information:

			***-**-__ __ __ __
Applicant's Last Name	**First Name**	**M.I.**	**Social Security # (last four)**

Basis of Disability Retirement (Please describe):

Type of Disability (Please check one):

- ☐ **Accidental**
- ☐ **Ordinary**
- ☐ **Either Accidental or Ordinary**

Employer Information:

Name of Dept./Agency:					
Name of Direct Supervisor:			**Title:**		
Street Address:					
City/Town:		**State:**		**Zip:**	
Phone Number:		**Fax Number:**			
Email:					
Name of Department Head:			**Title:**		

- Form last updated: 9/17/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Employer's Statement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Applicant's Current Employment

1. Applicant's current job title:
2. Date employment began: Date employment ended:
3. Last date able to perform the essential duties of the position:
4. Is the position classified under Civil Service? **YES** **NO**
5. Please describe the essential duties that the applicant is required to perform in his or her current position (Please see the last page of this document for a definition of essential duties.)
6. How frequently is the applicant required to perform these essential duties?
7. Please describe the physical or mental requirements of the applicant's current position. (For example, how much lifting, bending, strength, etc. is necessary.)
8. Of the physical or mental requirements described above, are there any that the applicant cannot perform because of the claimed disability? **YES** **NO**
9. Is the applicant currently performing in an accommodated position? **YES** **NO**
   - **If yes,** attach the accommodated job description.
   - **If yes,** how long have they been in the accommodated position?
   - **If yes,** is this a temporary or permanent accommodation?
10. Could the applicant perform the essential duties of his or her current position if he or she was reasonably accommodated? **YES** **NO**
11. If the applicant is not in an accommodated position, are there any accommodated positions that the applicant could hold currently? **YES** **NO**
    If yes, please explain:
12. Has this employee been officially investigated for or charged with misappropriation of funds from his/her employer or convicted of any crime related to his/her office or position? **YES** **NO**
    If **YES**, please provide documentation.

- Form last updated: 9/17/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Employer's Statement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Medical Condition & Current Employment

1. Has the applicant's medical condition affected his or her attendance and job performance?
   YES **NO** **Please describe how.**

2. Did the applicant request any modification of job duties in order to accommodate his or her medical condition?
   YES **NO** **If yes, please explain.**

3. Has your department offered any modification of job duties or other reasonable accommodations to the applicant because of his or her medical condition? **YES** **NO** **If yes, please explain.** Attach the modified job description.

4. Did the applicant file any grievances or legal claims against your department that could be related to his or her claim for disability? **YES** **NO** If yes, please explain the status of any such grievance or claim.

5. Based on the applicant's claim of disability, has your department conducted any tests or studies on the building in which your department is located or the surrounding grounds? **YES** **NO** **If yes, please explain.** Attach any available documentation regarding tests or studies done.

6. Is the applicant's claimed disability the result of or in any way related to, a personnel action? **YES** **NO**
   If yes, please explain.

7. Is the applicant's claimed disability the result of any misconduct on his/her part? **YES** **NO** **If yes, please explain.**

- Form last updated: 9/17/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Employer's Statement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Circumstances Related to Claim of Accidental Disability

If you are aware of any incidents or hazards that are related to the applicant's job duties that may have caused or contributed to the applicant's claimed disability, provide information about them, in as specific a manner as possible, in the following section. Please attach any Injury or Incident reports regarding the claimed disability filed by this applicant. If the space provided proves to be insufficient, you may attach additional sheets to this document. If you are not aware of any such job related incidents or hazards, skip this section.

One of the conditions for receiving approval of an application for accidental disability retirement benefits is that the retirement board must find that the applicant's disability is the natural and proximate result of either:

- A personal injury sustained (usually, one or several specific incidents) or
- A hazard undergone (generally, exposure to a harmful situation over a period of time).

Occurrence #1

Incident or Hazard Related to the Applicant's Job Duties

Date of occurence **Time** **Location**

Description of Incident or Hazard

Witness Data Related to Occurrence #1 of an Incident or Hazard Related to the Applicant's Job Duties:

Please provide the following information about each individual who witnessed the incident or hazard (related to the applicant's job duties) described above. Attach additional sheets if necessary.

Witness 1:
Relationship to Applicant:
Street Address:
City/Town: **State:** **Zip:**
Phone Number: **Email:**

Witness 2:
Relationship to Applicant:
Street Address:
City/Town: **State:** **Zip:**
Phone Number: **Email:**

- Form last updated: 9/17/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Employer's Statement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Circumstances Related to Claim of Accidental Disability *(Continued)*

Occurrence #2

Incident or Hazard Related to the Applicant's Job Duties

Date of occurence	Time	Location

Description of Incident or Hazard

Witness Data Related to Occurrence #2 of an Incident or Hazard Related to the Applicant's Job Duties:

Please provide the following information about each individual who witnessed the incident or hazard (related to the applicant's job duties) described above. Attach additional sheets if necessary.

Witness 1:					
Relationship to Applicant:					
Street Address:					
City/Town:		**State:**		**Zip:**	
Phone Number:		**Email:**			
Witness 2:					
Relationship to Applicant:					
Street Address:					
City/Town:		**State:**		**Zip:**	
Phone Number:		**Email:**			

- Form last updated: 9/17/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Employer's Statement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Other Contributing Circumstances

Are you are aware of any incidents or hazards that are not related to the applicant's job duties that may have caused or contributed to the applicant's claimed disability?

- If so, provide information about them in the following section.
- If you are not aware of any such non-job related incidents or hazards, skip this section.

Occurrence #1

Incident or Hazard NOT Related to the Applicant's Job Duties

Date of occurence	Time	Location

Description of Incident or Hazard NOT Related to the Applicant's Job Duties

Witness Data Related to Occurrence of an Incident or Hazard NOT Related to the Applicant's Job Duties:

Please provide the following information about each individual who witnessed the incident or hazard (related to the applicant's job duties) described above.

Witness 1:					
Relationship to Applicant:					
Street Address:					
City/Town:		**State:**		**Zip:**	
Phone Number:		**Email:**			
Witness 2:					
Relationship to Applicant:					
Street Address:					
City/Town:		**State:**		**Zip:**	
Phone Number:		**Email:**			

- Form last updated: 9/17/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Employer's Statement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Early Intervention Plan

1. Has the applicant been offered an early intervention plan pursuant to G.L. c. 32, § 5B? **YES** **NO**

2. Has the applicant failed to participate in the assessment or required rehabilitation of an early intervention plan pursuant to G.L. c. 32, § 5B? **YES** **NO**

Workers' Compensation (Related to the Applicant's Claimed Disability)

1. Has the applicant applied for Workers' Compensation benefits for this claimed disability? **YES** **NO**
   If yes, please provide the date of application:

2. Has the applicant received or is he/she now receiving Workers' Compensation benefits for this claimed disability?
   YES **NO** If yes, please provide the following information:

   - Date weekly payments commenced:
   - Amount of weekly payment:
   - Date payments terminated, if relevant:
   - Did the Treasurer/DIA construct a rehabilitation plan in the course of the applicant's Workers' Compensation claim?
     YES **NO** If yes, please provide the documentation.

3. Has the applicant received a Workers' Compensation settlement for this claimed disability? **YES** **NO**
   If yes, record the date the settlement was awarded:

Section 111F Benefits (Related to the Applicant's Claimed Disability)

1. Has the applicant received or is he or she receiving benefits pursuant to G.L. c. 41, § 111F? **YES** **NO**

   If yes, please provide dates for the periods during which § 111F benefits are or were being paid:

- Form last updated: 9/17/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Employer's Statement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Required Signatures

I, the undersigned, have been authorized by the department/agency listed on page 1 to prepare this statement. I understand that the above named applicant has applied for disability retirement pursuant to the provisions of Massachusetts General Laws Chapter 32. I certify that I have read and understand the information contained in this statement, and I subscribe, under the penalties of perjury, that the information I have supplied in this statement is true, complete and accurate to the best of my knowledge.

Name of Direct Supervisor (Print):

Signature of Direct Supervisor: **Date:**

I, the undersigned, have been authorized by the department/agency listed on page 1 to counter sign this statement. I certify that I have read and understand the information contained in this statement, and I subscribe, under the penalties of perjury, that the information supplied in this statement is true, complete and accurate to the best of my knowledge.

Name of Department Head (Print):

Signature of Department Head: **Date:**

- Form last updated: 9/17/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Employer's Statement

Determination of Essential Duties

In connection with all applications for disability retirement and evaluations, a determination of the essential duties of the relevant job or position shall be made.

The determination of what constitutes an essential duty of a job or position is to be made by the employer, based on all relevant facts and circumstances and after consideration of a number of factors.

Please note that if the Commonwealth's Human Resources Division has promulgated a list or description of essential duties for a position that is consistent with those of the member's position, the employer shall submit such a list or description as the essential duties for the position in question.

The telephone number of the Commonwealth's Human Resources Division is 617-878-9700. Their website address is www.mass.gov/hrd. It is anticipated that job specifications will be posted there. The term "essential duties" as used in Massachusetts General Laws, Chapter 32 and in all regulations promulgated by the Public Employee Retirement Administration Commission shall mean those duties or functions of a job or position which must necessarily be performed by an employee to accomplish the principal objective(s) of the job or position. The essential duties of a position are those that bear more than a marginal relationship to the position.

In making the determination as to whether a function or duty is essential, the employer shall consider and provide documentation to include, but not be limited to:

- The nature of the employer's operation and the organizational structure of the employer;
- Current written job descriptions;
- Whether the employer requires all employees in a particular position to be prepared to perform a specific duty;
- The number of employees available, if any, among whom the performance of the job function can be distributed;
- The amount of time that employees spend performing the function;
- Whether the function is so highly specialized that the person in the position was hired for his or her special ability to perform the function;
- The consequences of not requiring the employee to perform the function;
- The actual experience of those persons who hold and have held the position or similar positions; and
- Collective bargaining agreements.

- Form last updated: 9/17/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Employer's Statement

Disability Type: **Member:** **SSN:** ***-**-__ __ __ __

Addendum Sheet to the Employer's Statement Pertaining to Member's Application for Disability Retirement

Please use this sheet to provide further information in the event that you find the space provided on the form to be insufficient. Please identify the question(s), by Page Number and Question Number, for which you are providing further information.

- Form last updated: 9/17/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Treating Physician's Statement Pertaining to a Member's Application for Disability Retirement

Updated October, 2018

Who should prepare this form?

In accordance with 840 CMR 10.06(1)(b) (Code of Massachusetts Regulations), every member-applicant shall file a statement from a licensed medical doctor.

Who will ask the physician to complete this form?

In the *Disability Retirement Application* that an applicant submits to his/her retirement board, the applicant will identify the name, address, and phone number of the physician who has provided the care for his/her disability. The retirement board will send a copy of the Treating Physician's Statement to the physician and request that the form be completed and returned to the retirement board.

Some applicants may choose to submit the *Treating Physician's Statement* directly to their physician. Applicants should be sure to include the name, address, and phone number of their retirement board on the statement, if they take this course of action.

In order to avoid duplication of effort, if an applicant does submit the *Treating Physician's Statement* directly to his/her physician, the applicant should be sure to inform his/her retirement board.

What is the process associated with this form?

A voluntary disability retirement application will not be considered complete until the completed *Treating Physician's Statement* has been received by the applicant's retirement board. Delays in filing any of the required materials will impede timely processing of the application.

Are there terms particular to the legal process of disability retirement that the physician should consider when completing the Treating Physician's Statement?

Yes, please review the last two pages of the *Treating Physician's Statement*. Definitions are included for: Accidental Disability, Ordinary Disability, Risk of Re-injury, Aggravation of a Pre-Existing Condition, and the Permanency Standard.

Presumptions: If the applicant is applying for disability retirement for a heart, lung or cancer presumption, please review the definitions on page 9 of this form regarding the Heart, Lung or Cancer Presumptions.

Who should a treating physician contact if he or she has questions about this form?

If a treating physician needs further explanation about this form or the disability process in general, the physician should contact the applicant's retirement board.

■ Form last updated: 9/18/18

Treating Physician's Statement Pertaining to a Member's Application for Disability Retirement

Updated October, 2018 2

Please return this form to:

Name of Retirement Board:			
Address:			
City/Town:		**Zip Code:**	
Telephone:		**Fax:**	
Email:			

Applicant Information:

			***-**-____ ____ ____ ____
Applicant's Last Name	**First Name**	**M.I.**	**Social Security # (last four)**

Former or Maiden Name (If different from above):

Street Address:					
City/Town:		**State:**		**Zip:**	
Phone Number:		**Fax Number:**			
Email:					

Type of Claimed Disability (Please check one):

☐ **Accidental** ☐ **Ordinary** ☐ **Either Accidental or Ordinary**

■ Form last updated: 9/18/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Treating Physician's Statement

Applicant Last Name: **First Name:** **SSN:** ***-**-__ __ __ __

Note to Physician:

As a physician who has been treating the above named applicant for his or her claimed disability, the retirement board will consider your analysis of the applicant's medical condition. Attention to this document will help you translate medical findings and opinions into language consistent with Massachusetts law, which in turn will help your patient with the process. All definitions are included on page 9.

Introduction:

- You are asked to answer yes or no to questions (1) and (2) if the applicant is filing for an ordinary disability;
- You are asked to answer yes or no to questions (1), (2), and (3A) if the applicant is filing for accidental disability ***without*** a presumption; and
- You are asked to answer yes or no to questions (1), (2), and (3B) if the applicant is filing for accidental disability ***under*** a presumption.

Applications for Accidental Disability under the Heart, Lung or Cancer Presumption

- The treating physician submitting this form for a member who is applying for accidental disability benefits under the Heart, Lung or Cancer presumption should note that certain conditions are presumed to be job-related if suffered by persons holding certain public safety positions. The treating physician should be aware that a higher level of certainty (higher than what a doctor typically refers to, i.e., reasonable degree of medical certainty) will be required to overcome or rebut a presumption. Overcoming a presumption requires a uniquely predominate non-work related influence.
- The presumptions are found in G.L. c. 32, §§ 94, 94A, and 94B; they are the Heart, Lung, and Cancer Presumptions. Please review the definitions and attached guides to completing these presumptions before completing this form.

Manner of Submission

- You may either complete the narrative section of this report by handwriting your responses, or submitting a narrative utilizing the items listed as your template. Your office notes and test results may be attached to further substantiate your conclusions.

- Form last updated: 9/18/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Treating Physician's Statement

Applicant Last Name: **First Name:** **SSN:** ***-**-__ __ __ __

Question #1 - Incapacity

- Applicant's Date(s) of injury(ies) or exposure(s):
- What are the applicant's medical diagnoses?
- Please list key tests or imaging or other data confirming diagnoses:
- Applicant's Job Title:
- Were the job duties reviewed? ☐ Yes ☐ No
- When was this applicant last able to perform his or her essential duties?
- Are there any essential duties that cannot be performed by the applicant?
- Are there any medical restrictions that prevent the applicant from performing the essential duties of their position?

Question 1 - incapacity:

Is the applicant mentally or physically ***incapable*** of performing the essential duties of his or her particular job? ☐ Yes ☐ No

- Form last updated: 9/18/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Treating Physician's Statement

Applicant Last Name: **First Name:** **SSN:** ***-**-__ __ __ __

Question #2 - Permanency (Please refer to the attached Permanency Standard)

- Has the condition(s) changed over time? ☐ Yes ☐ No
- In the past 3 months? ☐ Yes ☐ No (If yes, please describe how below)
- In the past year? ☐ Yes ☐ No (If yes, please describe how below)
- Your assessment of anticipated natural course of the diagnoses

  ☐ Stable or plateau ☐ Likely to regress ☐ Likely to resolve
- Has Maximum Medical Improvement (MMI) been reached? ☐ Yes ☐ No

Non-surgical therapeutic interventions and outcomes:

Medications:

PT:

Chiropractic:

Other:

Surgical interventions and outcomes:

Type of Surgery: Date (mm/dd/yyyy):

Outcome:

Type of Surgery: Date (mm/dd/yyyy):

Outcome:

Type of Surgery: Date (mm/dd/yyyy):

Outcome:

Type of Surgery: Date (mm/dd/yyyy):

Outcome:

(Section continued, next page)

■ Form last updated: 9/18/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Treating Physician's Statement

Applicant Last Name: **First Name:** **SSN:** ***-**-__ __ __ __

Question #2 - Permanency (continued from previous page)

Pursuant to PERAC Regulation 840 CMR 10.04(1)(b) please answer the following questions:

- Is the nature of the condition or injury such that it can be expected to improve over a reasonable period of time? ☐ Yes ☐ No Please explain:

- Is the nature of the condition or injury such that it could be expected to improve if the member were willing to undergo reasonable medical treatment or rehabilitation? ☐ Yes ☐ No Please Explain:

Question 2 - permanency:

Is the condition for which the applicant seeks disability retirement likely to be ***permanent***? ☐ Yes ☐ No

Complete question 3A if the member is filing an application for accidental disability ***without a presumption.***

Question #3A - Causation (without a presumption)

- Describe the event(s) or onset of condition(s) that in your opinion led to applicant's disability:

- What other life event/circumstance/condition in the applicant's medical history may have contributed to or resulted in the disability claimed?

- Upon weighing the medical evidence, is it more likely that the disability was caused by the job-related personal injury or hazard undergone, or the non-work related event or circumstance or condition?

Question 3A - causation without presumptions:

Is said incapacity such as might be the natural and proximate result of the claimed personal injury sustained or hazard undergone while in the performance of the applicant's duties? ☐ Yes ☐ No

- Form last updated: 9/18/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Treating Physician's Statement

Applicant Last Name: **First Name:** **SSN:** ***-**-__ __ __ __

Complete question 3B if the member is filing an application for accidental disability ***under the Heart, Lung or Cancer presumption.***

Question #3B - Causation (with a presumption)

A presumption can be rebutted only by documentation of a uniquely predominant influence that shows the disability is not job-related or caused by a non-service connected accident or hazard.

If there is no evidence of such influence then you must answer yes. If there is such influence, you must answer no to the question below.

Question 3B - causation with presumptions:

For this particular applicant, is there no evidence of a uniquely predominant non-service connected influence on his/her mental or physical condition and/or a non-service connected accident or hazard which caused his/her incapacity? ☐ Yes ☐ No

If you answer No to Question 3B, please explain the uniquely predominant influence which brings you to this conclusion:

■ Form last updated: 9/18/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Treating Physician's Statement

Applicant Last Name: **First Name:** **SSN:** ***-**-__ __ __ __

Physician's Certification

Physician Information:

Name:

Street Address:

City/Town: **State:** **Zip:**

Phone Number: **Fax Number:**

Email:

I am certified to practice medicine in:
(list all states that apply)

Medical license number :

Date issued (mm/dd/yyyy):

License issued by (state):

Medical Specialty:

Physician Signature:

I, the undersigned physician, understand that _____ has applied for disability retirement pursuant to the provisions of Massachusetts General Laws, Chapter 32.

I have knowledge of the pertinent facts of this patient's case as described.

I certify that I have read and understand the information contained in this statement, and subscribe, under the penalties of perjury, that the information I have supplied in this statement and in my medical reports (if applicable) is true, complete, and correct to the best of my knowledge.

M.D.

Signature Date

■ Form last updated: 9/18/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Treating Physician's Statement

Definition of Terms:

Ordinary Disability In an application for Ordinary Disability Retirement, an applicant does not assert that his or her disability is the result of a job-related incident or injury. For such applications, your response to Question 3 is not necessary. But please note that you may also respond to Question 3, if your determination is that consideration of causality is appropriate even though the applicant has not applied for accidental disability retirement.

Accidental Disability In an application for Accidental Disability Retirement, an applicant asserts that his or her disability is the result of a job-related incident or injury. For such applications, your responses to Questions 1, 2, and 3 are required.

Aggravation of a Pre-Existing Condition You may find that a previous condition or injury is related to the condition or injury that is the basis of the disability application. If the acceleration of a pre-existing condition or injury is as a result of an accident or hazard undergone, in performance of the applicant's duties, causation would be established. However, if the disability is due to the natural progression of the pre-existing condition or was not aggravated by the alleged injury sustained or hazard undergone, causation would not be established.

Risk of Re-injury The Contributory Retirement Appeal Board (CRAB) has found, "…even if a member is physically capable of performing all of the essential duties of his or her position, he or she may be disqualified if a return to work would pose an unreasonable risk to serious harm to the member or third parties." *Filipek v. Bristol County Retirement Board*, CR-03-672 (CRAB 12/23/04). This risk of re-injury has to reasonably be expected to involve a substantial harm.

Last Date of Service The Contributory Retirement Appeal Board (CRAB) has found, an "employee who has left government service without established disability may not, after termination of government service, claim accidental disability retirement status on basis of subsequently matured disability" You are asked to address whether the member was disabled at the time he or she last performed their job duties. *Vest v. Contributory Retirement Appeals Board*, 41 Mass. App. Ct. 191, 194 (1996).

Permanency Standard A disability is permanent if it will continue for an indefinite period of time that is likely to never end even though recovery at some remote, unknown time is possible. If you are unable to determine when the applicant will no longer be disabled, you must consider the disability to be permanent. However, if the recovery is reasonably certain after a fairly definite time, the disability cannot be classified as permanent. It is imperative that the physician makes his/her determination based on the actual examination of the applicant and other available medical tests or medical records that have been provided.

Presumptions Certain conditions are presumed to be job-related if suffered by persons holding certain public safety positions. Additional information about these presumptions is available from the Public Employee Retirement Administration Commission.
The presumptions are:

- **Heart Presumption (G.L. c. 32, § 94)**
  A disability or death caused by heart disease or hypertension is presumed to be suffered in the line of duty for public safety positions, including certain fire fighters, police officers, corrections officers, and public safety employees at the international airport. The employee must have passed a physical examination on or after their date of hire which failed to reveal evidence of such a condition. The presumption can be rebutted by competent evidence which shows the disability was not job-related.

- **Lung Presumption (G.L. c. 32, § 94A)**
  A disability or death caused by diseases of the lungs or respiratory tract is presumed to be suffered in the line of duty as a result of inhalation of noxious fumes or poisonous gas for certain fire fighters or public safety employees at the international airport. The employee must have passed a physical examination on or after their date of hire which failed to reveal evidence of such a condition. The presumption can be rebutted by competent evidence which shows the disability was not job-related.

- **Cancer Presumption (G.L. c. 32, § 94B)**
  A disability or death caused by certain cancers is presumed to be suffered in the line of duty as a result of exposure to heat, radiant, or a known or suspected carcinogen for certain qualified fire fighters or public safety employees. The employee (or retiree) must have been employed in an eligible position on or after July 5, 1990, must have served in such a position for five years or more at the time such condition is or should have discovered, must have regularly responded to fires during some portion of his/her service, and must discover or should have been discovered cancer within five years of the last date of his/her active service. The presumption can be rebutted by a preponderance of the evidence that shows that the disability was caused by non-service-related risk factors or accidents or hazards undergone.

- Form last updated: 9/18/18

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction
Involuntary Retirement Application (To Be Filed By An Employer)

Form Last Revised: October, 2018

Who should use this form?
A department head may file an *Involuntary Retirement Application* to retire a public employee upon the basis of disability or superannuation. The minimum creditable service and age requirements that apply to applications filed by members are also applied to those members whose retirement proceedings are initiated by their employer.

How does the department head initiate the involuntary retirement process?
The department head will file an *Involuntary Retirement Application* with the member's retirement board. No information or statement from the member is required to complete the form. At the same time that the department head files the application with the member's retirement board, the department head must also send to the member, via certified mail, a copy of the application, a brief statement of the member's retirement options, and a statement of the member's rights to a hearing and review. The department head must file a notice of delivery, including the certified mail return receipt, with the member's retirement board.

Does a member have any immediate recourse if he/she feels he/she should not be retired?
Within 15 days of the member's receipt of the copy of the application from the department head, the member may request a hearing before his/her retirement board if he/she is a member-in-service who has attained age 55 and who has completed 15 or more years of creditable service, or if the member hasn't attained age 55, but has completed 20 or more years of creditable service.

Does a member have appeal rights if they are involuntarily retired?
Any member who has been involuntarily retired and has attained age 55 and completed 15 or more years of creditable service, or any member so classified who has not attained age 55 but who has completed 20 or more years of creditable service, or any such member who is a veteran and has completed 10 or more years of creditable service may seek review of such action in the district court in the district in which he(she) resides within 30 days after the certification of the retirement board's decision.

For employers who have filed an involunary application on the basis of a disability Will the process include a medical examination and evaluation?
If a member is not entitled to an initial hearing and/or the board accepts the appropriateness of the disability application, the involuntary process will continue through the same medical evaluation process that governs a voluntary application for a disability retirement.

- Form last updated: 9/17/18

Involuntary Retirement Application (To Be Filed By An Employer)

Form Last Revised: October, 2018

RETIREMENT BOARD: Please place your address, phone number, fax number and email address here.

Name of Retirement Board:

Address:

Phone Number: **Fax Number:**

Email:

To: Retirement Board

This is an application to involuntarily retire the member named below. Attached is an explanation of the member's rights to a hearing and to appeal, and a brief statement of the member's retirement options. The member should contact his/her retirement board for further information or assistance.

A fair summary of the reasons for filing this application is below. The retirement board will review this application, together with information supplied by the employer and, if desired, by the member. If appropriate, the retirement board may then request a regional medical panel be convened. Based on the information gathered and the medical panel's opinion, the board will vote whether to approve or deny this application. The application will then be forwarded to the Public Employee Retirement Administration Commission for review.

Pursuant to G.L. c. 32, §16(1), I respectfully request that (name of member), whose Social Security Number is ***-**-_____ _____ _____ _____, be retired on the basis of (please check all that apply):

☐ **ORDINARY DISABILITY** ☐ **ACCIDENTAL DISABILITY** ☐ **EITHER ORDINARY OR ACCIDENTAL DISABILITY** ☐ **SUPERANNUATION**

I offer the following fair summary of facts as the basis for my opinion that the member should be involuntarily retired:

*Attach additional sheet if necessary

Has this employee been officially investigated for or charged with misappropriation of funds from his/her employer or convicted of any crime related to his/her office or position? **YES** ☐ **NO** ☐ If **YES**, please provide documentation.

I am submitting this form and the following attachments to the member's retirement board:

- The member's job description that includes all of his/her duties and responsibilities. I have specified those duties that are considered to be essential.
- Copies of all applicable medical information and incident reports in the employer's possession.
- *Employer's Statement* Form
- A notice of delivery to the member, including the certified mail return receipt, of a copy of all pages of this application form, which includes a statement of the member's retirement options and a statement of the member's rights to a hearing and review.

Name of Department Head (Print)	**Title of Department Head**
Signature of Department Head	**Date**

- Form last updated: 9/17/18

Involuntary Retirement Application (To Be Filed By An Employer)

Chapter 32: Section 16 of the General Laws of Massachusetts Involuntary Retirement; Right to a Hearing; Right of Review or Appeal.

Section 16 (1): Involuntary Retirement and Right to a Hearing

(a) Any head of a department who is of the opinion that any member employed therein should be retired for superannuation, ordinary disability or accidental disability, in accordance with the provisions of section five, six, or seven, as the case may be, may file with the board on a prescribed form a written application for such retirement. Such application shall include a fair summary of the facts upon which such opinion is premised. The applicant shall forthwith deliver to such member by registered mail, with a return receipt requested, a true copy of such application, together with a brief statement of the options available to such member on his retirement and a statement of his right, if any, to request a hearing with regard to such retirement and of the right, if any, of review available to him, as provided for in this section, in case he is aggrieved by any action taken or decision of the board rendered or by failure of the board to act upon his request or to render a decision within the time specified in this subdivision. Upon such delivery to such member the head of the department, or one acting in his behalf, shall file with the board under the penalties of perjury a written notice of such delivery, including the date thereof.

(b) (i) Any member in service, classified in Group 1, Group 2 or Group 4 who has attained age 55 and completed 15 or more years of creditable service;

(ii) any member in service, classified in Group 1, Group 2 or Group 4 who has not attained age 55 but who has completed 20 or more years of creditable service;

(iii) any member in service, who entered such service on or after April 2, 2012, classified in Group 1 who has attained age 60 and completed 15 or more years of creditable service; or

(iv) any member in service, who entered such service on or after April 2, 2012, classified in Group 1 who has not attained age 60 but who has completed 20 or more years of creditable service, for whom an application for such member's retirement is filed by the head of such member's department under paragraph (a) of this subdivision, may, within 15 days of the receipt of such member's copy of such application, file with the board a written request for a private or public hearing upon such application. If no such request is so filed, the facts set forth in such application shall be deemed to be admitted by such member; otherwise such hearing shall be held not less than ten nor more than thirty days after the filing of the request. The board, after giving due notice, shall conduct such hearing in such manner and at such time or times as the best interests of all parties concerned may require. The board shall prepare and file with its clerk or secretary a certificate containing its findings and decision, copies of which shall be sent to the proper parties within fifteen days after completion of such hearing.

(c) If the board finds that any member should be retired under the provisions of this subdivision, he shall receive the same retirement allowance as he would have received had the application been made by himself. If the board finds that such member should not be retired, he shall continue in his office or position without loss of compensation, subject to the provisions of sections one to twenty-eight inclusive, as though no such application had been made.

(There is no subdivision (2)

- Form last updated: 9/17/18

Involuntary Retirement Application (To Be Filed By An Employer)

Section 16 (3): Right of Review by District Court

(a) Any member classified in Group 1, Group 2 or Group 4 who has attained age fifty-five and completed fifteen or more years of creditable service, or any member so classified who has not attained age fifty-five but who has completed twenty or more years of creditable service, or any such member who is a veteran and has completed ten or more years of creditable service, and who is aggrieved by any action taken or decision of a board or the public employee retirement administration commission rendered with reference to his involuntary retirement under the provisions of subdivision (1), or any member who is aggrieved by any action taken or decision of a board or the public employee retirement administration commission rendered with reference to his dereliction of duty as set forth in section fifteen, may, within thirty days after the certification of the decision of the board, bring a petition in the district court within the territorial jurisdiction in which he resides praying that such action and decision be reviewed by the court. After such notice as the court deems necessary, it shall review such action and decision, hear any and all evidence and determine whether such action was justified. If the court finds that such action was justified the decision of the board or the public employee retirement administration commission shall be affirmed; otherwise it shall be reversed and of no effect. If the court finds that such member was unjustifiably retired under subdivision (1) from the member's office or position, the member shall be reinstated thereto without loss of compensation. The decision of the court shall be final.

(b) Any member whose office or position is subject to chapter thirty-one or to the rules and regulations made under authority thereof, who is aggrieved by any action taken or decision of a board or the public employee retirement administration commission rendered as described in paragraph (a) of this subdivision shall, for the purposes of sections one to twenty-eight, inclusive, have and retain such of the rights provided by sections forty-two A, forty-two B, forty-three and forty-five of chapter thirty-one as applied to his particular office or position, and the court shall, in addition to the matters it is required to review under such sections of chapter thirty-one, affirm or disaffirm the decision of the board or the public employee retirement administration commission as provided for in paragraph (a) of this subdivision.

Section 16 (4): Right of Appeal to Contributory Retirement Appeal Board

There shall be an unpaid contributory retirement appeal board which shall consist of three members as follows: an assistant attorney general who shall be designated in writing from time to time by the attorney general who shall act as chairman, the public employee retirement administration commission or an assistant who shall be designated in writing, from time to time, by the said commission, and a member appointed by the governor for a term of five years. In the event the matter before the contributory retirement appeal board deals with any matter related to disability retirement or interim benefits as awarded by the division of administrative law appeals, the commissioner of public health or his designee shall substitute for the public employee retirement administration commission.

The members of the contributory retirement appeal board shall be compensated for any expenses incurred in the performance of their official duties. On matters other than those subject to review by the district court as provided for in subdivision (3), or other than those which would have been subject to review had the requirement for the minimum period of creditable service been fulfilled, any person when aggrieved by any action taken or decision of the retirement board or the public employee retirement administration commission rendered, or by the failure of a retirement board or the public employee retirement administration commission to act, may appeal to the contributory retirement appeal board by filing therewith a claim in writing within fifteen days of notification of such action or decision of the retirement board or the commission, or may so appeal within fifteen days after the expiration of the time specified in sections one to twenty-eight, inclusive, within which a board or the commission must act upon a written request thereto, or within fifteen days after the expiration of one month following the date of filing a written request with the board or the commission if no time for action thereon is specified, in case the board or the commission failed to act thereon within the time specified or within one month, as the case may be. The contributory retirement appeal board, after giving due notice, shall, not less than ten nor more than sixty days after filing of any such claim of appeal, assign such appeal to the division of administrative law appeals for a hearing. The division of administrative law appeals shall maintain the official

- Form last updated: 9/17/18

Involuntary Retirement Application (To Be Filed By An Employer)

Section 16 (4): Right of Appeal to Contributory Retirement Appeal Board *(Continued)*

records of the contributory retirement appeal board. After the conclusion of such hearing, the division of Administrative Law Appeals shall submit to the parties a written decision which shall be final and binding upon the board involved and upon all other parties, and shall be complied with by such board and by such parties, unless within fifteen days after such decision, (1) either party objects to such decision, in writing, to the contributory retirement appeal board, or (2) the contributory retirement appeal board orders, in writing, that said board shall review such decision and take such further action as is appropriate and consistent with the appeal provided by this section. The contributory retirement appeal board shall then pass upon the appeal within six months after the conclusion of such hearing, and its decision shall be final and binding upon the board involved and upon all other parties, and shall be complied with by such board and by such parties. Any person, upon making an appeal involving a disability retirement allowance, shall be permitted to retire for superannuation retirement, if otherwise eligible, pending the decision of the contributory retirement appeal board, but in no event shall such action prejudice the person from receiving any further benefits which the contributory retirement appeal board may grant in its decision nor shall the person upon a finding in favor of the employer be required to reimburse the employer for payments made prior to the decision of the contributory retirement appeal board.

On appeals involving disability or where medical reports are part of the proceedings, the contributory retirement appeal board may request further information from the members of the appropriate regional medical panel, or may employ a registered physician to advise them in determination of an appeal.

The contributory retirement appeal board shall have the power to subpoena witnesses, administer oaths and examine such parts of the books and records of the parties to a proceeding as relate to questions in dispute. Fees for such witnesses shall be the same as for witnesses before the courts in civil actions, and shall be paid from the Appropriation Fund of the division of administrative law appeals.

The contributory retirement appeal board, acting through the division of administrative law appeals, shall arrange for the publication of its decisions and the cost of such publication shall be paid from the Appropriation Fund of the division of administrative law appeals.

The contributory retirement appeal board shall establish a fee structure for appeals brought under this section, which shall be subject to the approval of the commissioner of administration.

The division of administrative law appeals shall submit to the contributory retirement appeal board on an annual basis a report on the status of all cases that have been assigned to the division of administrative law appeals for a hearing.

(5): Provisions Not Applicable to Certain Members

The provisions of this section relative to the right of any member to a hearing or to the right of review by the district court shall not apply in the case of the removal or discharge of any state official or of any official of any political subdivision of the commonwealth for which provision is otherwise made in any general or special law, anything in this section to the contrary notwithstanding. The provisions of this section relative to the right of any member to a hearing or to the right of review by the district court shall not apply to any teacher or principal or superintendent of schools employed at discretion or any superintendent employed under a contract, for the duration of his contract, or any principal or supervisor, who has been dismissed, demoted, or removed from a position by a vote of a school committee under the provisions of section forty-two, forty-two A or section sixty-three of chapter seventy-one. The provisions of this section shall not apply to any member classified in Group 3.

- Form last updated: 9/17/18

Involuntary Retirement Application (To Be Filed By An Employer)

Statement of the Member's Retirement Options

Your retirement board will provide you with a *Choice of Retirement Option Form*, and will assist you in making an informed selection about selecting the option that is best for you, but a brief description of the options available to you is included here. Any public employee who retires on the basis of ordinary or accidental disability or superannuation may elect to have his or her retirement allowance paid according to one of the three following Options. ***If you fail to select an Option, the allowance will be paid under Option B.***

Option A

Election of Option A means that you will receive the full retirement allowance in monthly payments as long as you live. Allowance payments will cease upon your death and no benefits will be provided to your survivors.

Option B

Option B provides you with a lifetime allowance which is generally 2% to 5% less per month than Option A. The annuity portion of your allowance will be reduced to allow a benefit for your beneficiary. If your death occurs before the total payments of the annuity portion of your allowance equal your total accumulated deductions at your retirement, the unexpended balance of your total accumulated deductions will be paid to your surviving beneficiary of record, (or, if there is no beneficiary living, the person or persons who appear to be entitled in the judgement of your retirement board).

Option C

Selecting Option C means that the allowance payments that you receive during your lifetime will generally be approximately 5% to 10% less than those you would have received under Option A. Upon your death, your designated beneficiary will be paid a monthly allowance for the remainder of his or her lifetime. That allowance will be equal to two-thirds of the allowance which was being paid to you at the time of your death. Only your spouse, former spouse who has not remarried, child, father, mother, sister or brother may be your beneficiary.

Spousal Acknowledgment

The retirement option election of any married member is not valid unless the signature of the member's spouse indicating the member's spouse's knowledge and understanding of the retirement option selected accompanies it.

- Form last updated: 9/17/18

New Beneficiary Forms

- Beneficiary Selection Form for Option D
- Beneficiary Selection Form for Refund of Accumulated Deductions
- Application for Member Survivor Allowance
- Spousal Affidavit for Member Survivor Allowance

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Beneficiary Selection Form for Option D

(If Member Dies Before Retirement)

Form Last Revised: October, 2018

The *Beneficiary Selection Form for Option D* allows a member to select an eligible beneficiary to receive an allowance if the member dies before retirement. This is the Member Survivor allowance described at G.L. c. 32, § 12(2)(d) ("Option D").

The following needs to be kept in mind:

- This form must be filed with the retirement board.
- If you designate an eligible beneficiary on this form, and that beneficiary is living at the time of your death, the money in your annuity account will not be disbursed to anyone in a one-time, lump-sum payment, even if you have named them to receive such money on your *Beneficiary Selection Form for Refund of Accumulated Deductions*.
- Do not designate the same person as your Option D beneficiary and as your beneficiary for the refund of accumulated deductions.
- You may name only one person as the Option D beneficiary. That one person may be your spouse, your former spouse who is not remarried at the time of your death, your child, your father, your mother, your sister or your brother.
- If you select a beneficiary other than the spouse to whom you are married at the time of your death, your selection on this form may be superseded by the eligible spouse under the provisions of Option D if you die before retirement.
- If your personal situation changes (e.g. divorce, a domestic relations order goes into effect, your beneficiary dies), you should file a new form with your retirement board.
- If you file a new Option D form with your retirement board, it will supersede any and all prior Option D forms previously filed by you.
- When you sign this form, it should be witnessed by a disinterested party.
- To cancel an Option D beneficiary designation prior to retirement, your written notice must be filed with the retirement board.
- This form becomes void upon your retirement.

Beneficiary Selection Form for Option D
(If Member Dies Before Retirement)
Form Last Revised: October, 2018 **2**

Retirement Board: Please enter your retirement board information here.

Name of Retirement Board:

Address:

City/Town: **Zip:**

Member's Information:

Name:

Social Security #: **Phone:**

Street Address:

City/Town: **State:** **Zip:**

Email Address:

Choice of Option D Beneficiary

I, (Print Name) , a member of the Retirement System, hereby nominate the beneficiary listed below, under the provisions of G.L. c. 32, § 12(2)(d) to receive from the retirement system a benefit equal to the Option C retirement allowance which would otherwise have been payable to me, in the event that I die before being retired.

I understand that I may change my beneficiary designation at any time prior to my retirement and that upon my retirement this form becomes void.

I understand that this choice of Option D Beneficiary can be superceded if, at my death, I have at least two years of creditable service and leave a spouse to whom I have been married for over one year and with whom I am living on the date of my death, or if living apart, doing so for justifiable cause as determined by the Retirement Board.

Beneficiary

This person is my: ☐ Parent ☐ Sibling ☐ Former Spouse*, not remarried ☐ Spouse* ☐ Child

Name of Eligible Beneficiary:

Beneficiary's Date of Birth: *(attach birth record)* **Beneficiary's Social Security #:**

Beneficiary's Street Address:

City/Town: **State:** **Zip:**

*If beneficiary is your spouse or former spouse, a copy of your marriage certificate is required

Member's Signature:

Print Name:

Signature: **Date:**

To Be Completed By Witness

Print Name:

Street Address:

City/Town: **State:** **Zip:**

Signature: **Date:**

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction
Beneficiary Selection Form for Refund of Accumulated Deductions Pursuant to G.L. c. 32, § 11(2)(c)
(If Member Dies Before Retirement)
Form Last Revised: October, 2018

The *Beneficiary Selection Form for Refund of Accumulated Deductions* allows a member to select a beneficiary or beneficiaries to receive payment of accumulated deductions and other payments due a member if the member dies before retirement described at G.L. c. 32, § 11(2)(c).

The following needs to be kept in mind:

- This form must be filed with the retirement board.
- If you have designated an eligible beneficiary who is alive at the time of your death on the *Beneficiary Selection Form for Option D*, then the money in your annuity account will not be disbursed to anyone in a one-time lump-sum payment, even if you have designated them on this form.
- Any person or entity may be designated as your Refund of Accumulated Deductions beneficiary under Section 11(2)(c). You may designate multiple beneficiaries and must indicate the percentage of the annuity account that you wish each beneficiary to receive. The percentages must total 100%.
- Do not designate the same person as your Option D beneficiary and your Refund of Accumulated Deductions beneficiary.
- Your selection of a beneficiary on this form also may be superseded by an eligible spouse under the provisions of Option D.
- If your personal situation changes (e.g. divorce, a domestic relations order goes into effect, your beneficiary dies), you should file a new form with your retirement board.
- If you file a new Section 11(2)(c) form with your retirement board, it will supersede any and all prior Section 11(2)(c) forms filed previously by you.
- When you sign this form, it should be witnessed by a disinterested party.
- This form becomes void upon your retirement.

Beneficiary Selection Form for Refund of Accumulated Deductions Pursuant to G.L. c. 32, § 11(2)(c)

(If Member Dies Before Retirement)

Form Last Revised: October, 2018

RETIREMENT BOARD: Please enter your retirement board information here.

Name of Retirement Board:

Address:

City/Town: **Zip:**

Member's Information:

Name:

Social Security #: **Phone:**

Street Address:

City/Town: **State:** **Zip:**

Email Address:

Choice of Beneficiary or Beneficiaries to Receive a Refund of Accumulated Total Deductions at Member's Death:

- Any person or entity may be a beneficiary under G.L. c. 32, § 11(2)(c). Give complete name and address of each beneficiary below:

I, (Print Name) , a member of the Retirement System hereby request the Retirement Board to pay any sum referred to in G.L. c. 32, § 11(2)(c) due at my death to the following beneficiary or beneficiaries in the proportions designated below. The totals of all proportions for your primary and contingent beneficiaries must equal 100% each.

PRIMARY LUMP-SUM BENEFICIARY(IES)

Do NOT name any one person or entity as a beneficiary more than ONCE in this section.

Beneficiary's SS # (or tax ID # if an organization)	Name of Beneficiary			Address	Date of Birth	Relationship to You	% of Benefit*
	Last Name	First Name	MI				

*Total must equal 100%; if no percentages are indicated, benefit will be allocated equally among lump-sum beneficiaries. **100%**

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Beneficiary Selection Form for Refund of Accumulated Deductions

Member Last Name: **First Name:** **SSN:**

CONTINGENT LUMP-SUM BENEFICIARY(IES)

In the event that the named primary lump-sum beneficiary(ies), above, are not alive at the time of your death.

Beneficiary's SS # (or tax ID # if an organization)	Name of Beneficiary: Last Name	First Name	MI	Address	Date of Birth	Relationship to You	% of Benefit*

*Total must equal 100%; if no percentages are indicated, benefit will be allocated equally among lump-sum beneficaries. **100%**

I understand that my selection may be superseded if I die with an eligible beneficiary under Option D.

I understand that I may change my beneficiary designation at any time prior to my retirement and that upon my retirement, this form becomes void.

The types of payments covered under G.L. c. 32, § 11(2)(c) include:

- The one-time payment of the accumulated deductions credited to a member's account in the annuity savings fund at the date of death when the member's death occurs prior to his/her retirement.
- The amount of any uncashed checks payable to a member at his or her death.

Member's Signature:

Print Name:

Signature: **Date:**

To Be Completed By Witness:

Name (Print):

Street Address:

City/Town: **State:** **Zip:**

Signature: **Date:**

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction

Application for Member Survivor Allowance Under G.L. c. 32, § 12A

Form Last Revised: October, 2018

The *Application for Member Survivor Allowance Under G.L. c. 32, § 12A* permits a survivor to apply for an allowance while awaiting a determination of his or her eligibility for survivor benefits under G.L. c. 32, § 9 or § 100.

- This form must be filed with the retirement board.
- Copies of birth certificates for any eligible children must be filed with this application.
- A copy of your marriage certificate, (if applicable) also must be filed with this application.

Application for Member Survivor Allowance Under G.L. c. 32, § 12A

Form Last Revised: October, 2018

Retirement Board: Please enter member's retirement board information here.

Name of Retirement Board:	
Address:	
City/Town:	**Zip:**

I, (Print Name) _____, on behalf of myself and the eligible children (if any) of the deceased member, _____, do hereby apply for the Member Survivor Allowance pursuant to G.L. c. 32, § 12A, pending approval of Accidental Death benefits under the provisions of G.L. c. 32, § 9 or § 100.

Applicant Information:

Name:			
Street Address:			
City/Town:		**State:**	**Zip:**
Phone:		**Social Security #:**	
Name of Deceased Member:		**Member's Date of Death:**	
My Relationship to Member: (if spouse, include copy of marriage certificate)			

1. Does the late member have any children who are **under** age eighteen? **YES** ☐ **NO** ☐
   If **YES**, please complete information below and include a copy of each child's birth certificate.

Name	Date of Birth	Social Security #

2. Does the late member have any children who are **over** age eighteen and **under** age twenty-two who are full-time students? **YES** ☐ **NO** ☐ If **YES**, please complete information below and include a copy of each child's birth certificate and proof of student status.

Name	Date of Birth	Social Security #

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Member Survivor Allowance

Deceased Member Last Name: **First Name:** **SSN:**

3. Does the late member have any children who were **over** eighteen and mentally or physically incapacitated from earning on the date of the member's death? **YES** **NO**

If **YES**, please list complete information below, and include a copy of each child's birth certificate and proof of their incapacity.

Name	Date of Birth	Social Security #

I sign this form under the penalties of perjury. I affirm that the information presented in this form is correct, complete and accurately presented. I understand that giving false or incomplete information may subject me to the loss of benefits I may have received as well as civil and criminal penalties.

Applicant's Signature

Name (Print):

Signature: **Date:**

To Be Completed By Witness

Name (Print):

Street Address:

City/Town: **State:** **Zip:**

Signature: **Date:**

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION
FIVE MIDDLESEX AVENUE, SUITE 304 | SOMERVILLE, MA 02145

Introduction
Spousal Affidavit for Member Survivor Allowance Pursuant to G.L. c. 32, § 12(2)(d)
Form Last Revised: October 2018

The *Spousal Affidavit for Member Survivor Allowance* provides important information to allow a retirement board to determine a spouse's eligibility for and amount of survivor benefits under G.L. c. 32, § 12(2)(d) ("Option D").

- This form must be filed with the member's retirement board.
- Copies of birth certificates for any eligible children must be filed with this application.
- The spouse must file a copy of his/her marriage certificate with this affidavit.

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Spousal Affidavit for Member Survivor Allowance

RETIREMENT BOARD: Please enter your retirement board information here.

Name of Retirement Board:

Address:

City/Town: **Zip:**

Deceased Member Information:

Last Name	First Name	M.I.	Social Security #	Date of Death

1. Was the above named member a Veteran? **YES** **NO**
   If **YES**, a copy of the military Form DD-214 must be filed.

Applicant Information: This form must be completed by the individual seeking benefits.

Spouse/Applicant Name:

Social Security #: **Phone:**

Street Address:

City/Town: **State** **Zip**

Email Address:

Date of birth: You must submit a copy of your birth certificate with this form

Date of marriage: Please enter the date you were married to the deceased member. You must submit a copy of your marriage certificate with this form.

2. Were you married to and living with your spouse on the date of his/her death? **YES** **NO**
   If **NO,** please attach a statement providing the details about why you were living apart. You must establish the fact that any separation was for a justifiable cause other than your desertion or moral turpitude.

Additional Beneficiary Information:

3. Does the late member have any children who are **under** age eighteen? **YES** **NO**

   If **YES**, please complete informatin below and include a copy of each child's birth certificate.

Name	Date of Birth	Social Security #

PUBLIC EMPLOYEE RETIREMENT ADMINISTRATION COMMISSION

Spousal Affidavit for Member Survivor Allowance

Deceased Member Last Name: **First Name:** **SSN:** ***-**-__ __ __ __

Additional Beneficiary Information (continued):

4. Does the late member have any children who are **over** age eighteen and **under** age twenty-two who are full-time students? **YES** **NO**

   If **YES**, please complete informatin below and include a copy of each child's birth certificate and proof of student status.

Name	Date of Birth	Social Security #

5. Does the late member have any children who were **over** eighteen and mentally or physically incapacitated from earning on the date of the member's death? **YES** **NO**

   If **YES**, please please complete informatin below and include a copy of each child's birth certificate and proof of their incapacity.

Name	Date of Birth	Social Security #

I sign this form under the penalties of perjury. I affirm that the information presented in this form is correct, complete and accurately presented. I understand that giving false or incomplete information may subject me to the loss of benefits I may have received, as well as civil and criminal penalties.

Applicant's Signature:

Print Name:

Signature: **Date:**

To Be Completed By Witness:

Name (Print):

Street Address:

City/Town: **State:** **Zip:**

Signature: **Date:**

COMMONWEALTH OF MASSACHUSETTS
Public Employee Retirement Administration Commission
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