MUNICIPAL POLICE
EMPLOYEES' RETIREMENT SYSTEM

7722 Office Park Boulevard Suite 200 Baton Rouge, Louisiana 70809-7601
Phone 800.443.4248 / 225.929.7411 **Fax** 225.929.6542 **Web** lampers.org

DISABILITY RETIREMENT APPLICATION

Member's First Name | Middle Name | Last Name | Today's Date | Social Security Number

IMPORTANT: Complete the entire form. Follow the specific instructions for each section. All dates should be in MM/DD/YYYY format.

SECTION 1: MEMBER'S INFORMATION

Member's Mailing Address | City | State | Zip Code

Would you like your address changed to the above if it does not match our records?

☐ Yes ☐ No

Daytime Area Code/Phone Number | Evening Area Code/Phone Number | Member's Birth Date

Email Address

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed

SECTION 2: INSTRUCTIONS (This is the first of three forms to be completed)

Any person who, knowingly and with intent to defraud an insurance company or another person, files a statement containing any materially false information or conceals information for the purpose of misleading, concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Claimant's Initial Statement of Disability -- Be sure to answer all questions. Failure to do so may delay your claim. The Disability Report form must be completed by your agency and the Attending Physician's Statement form must be completed by your attending physician and submitted to MPERS at the address above. Attach a copy of your Social Security card and a copy of your birth certificate.

MPERS strongly suggests that you obtain a disability benefits estimate before submitting this application.

SECTION 3: MEMBER'S JOB INFORMATION

Job Title | Employing Municipality | Total Years of Service

In your own words, please describe the usual duties of your job: (If additional space is needed, attach a separate sheet.)

Social Security Number

Has your illness or injury caused you to change:

Your job duties? ☐ Yes ☐ No Your hours of work? ☐ Yes ☐ No Your attendance? ☐ Yes ☐ No

If yes, please identify the changes and their effective dates:

In your own words, briefly describe the accident/incident or illness that prevents, or prevented, you from working:

Last Date of Employment (if no longer employed) | Date of First Treatment for the Disability | Is your condition due to an accident/incident?

☐ Yes ☐ No

Date of Accident/Incident: | Location of Accident/Incident:

☐ Home ☐ Work ☐ Other:

If the condition was due to an accident/incident, describe how the accident/incident occurred:

Are you receiving worker's compensation? If yes, give the amount of compensation being received per week:

☐ Yes ☐ No

Name of the worker's compensation insurance company | Telephone number

SECTION 4: MEMBER'S ATTENDING PHYSICIAN INFORMATION

Please list the physician(s) who has your most recent medical records. If more than one, attach additional sheets.

Name of Attending Physician | Speciality/Degree

Date First Visited Doctor | Date Last Visited Doctor | Daytime Area Code/Phone Number

Mailing Address | City | State | Zip Code

Is this your family doctor? ☐ Yes ☐ No

If no, give name and address of your family doctor:

Social Security Number

Give name, address, and telephone number of any other doctors you have seen since your disability began:

Has a doctor told you to restrict your activities in any way? ☐ Yes ☐ No

If yes, list what he/she told you about restricting your activities:

Were you hospitalized? ☐ Yes ☐ No

If yes, list the hospital name and days of confinement:

Describe how any home duties, social activities, or ability to care for your personal needs are limited in any way:

List the name, address, and telephone number of any facilities where you have been seen for your injury or illness (Workers' Compensation Board, vocational rehab, social services, etc.):

Dates of Visits

Claim Number, if any

Type of Treatment or Examination Received

Social Security Number

SECTION 5: GENERAL INFORMATION

MPERS requires the following documents to complete the processing of your application:

1. Copy of birth certificate
2. Copy of Social Security cards for member, member's spouse, and all member's living children under age 18
3. Certified Divorce Decree, if applicable
4. Certified Matrimonial Contracts, Prenuptial Agreements, Separate Property Agreements, etc., if applicable
5. Copy of death certificate of former spouse, if applicable
6. Authorization for Direct Deposit form
7. W-4P, Withholding Certificate for Pension or Annuity Payments - If the form is not submitted, your federal tax withholding with be set as married with three exemptions.
8. Repayment of previously refunded contributions plus interest (see below).

YOUR APPLICATION WILL NOT BE CONSIDERED COMPLETE UNTIL MPERS HAS RECEIVED ALL OF THE REQUIRED DOCUMENTS AND PAYMENTS.

The application for disability must be received by MPERS prior to termination of employment unless compelling evidence is presented to prove that the disability occurred while you were an active member of MPERS. The Board of Trustees shall be the sole judge as to whether or not an application is valid. The average processing time is 60-90 days from the date the completed application and all required medical records are received by MPERS.

A minimum of 10 years of service credit is required for a non-duty-related disability. A duty related disability does not require a minimum amount of years of service.

Once all requested information is received by MPERS along with the completed application, an appointment will be made for you to be examined by a board designated physician at the expense of MPERS for determination of whether or not you qualify for a disability benefit.

SECTION 6: PREVIOUS ENROLLMENT

If you were at any time a member of this system, give name under which your membership was reported and dates employed.

From (Mo./Yr.) To (Mo./Yr.) Status

☐ Refunded ☐ Transfer ☐ Inactive

Are you now or you ever been a member of another Louisiana Public Retirement System? If Yes, which one(s)?

From (Mo./Yr.) To (Mo./Yr.)

What is your present status in the other LA public system?

☐ Retired ☐ Refunded ☐ Active ☐ Inactive (Resigned, left contributions on deposit)

R.S. 11:2223(B)(5) provides "no application for disability shall be approved until all previously refunded contribution from the system have been repaid, including compounded interest at the board-approved actuarial valuation rate thereon from the date of refund until repaid in full."

SECTION 7: MEMBER SIGNATURE AND AUTHORIZATION TO RELEASE INFORMATION

I authorize any employer, insurance company, Medical Insurance Bureau, Workers' Compensation Board, Social Security Administration, physician, practitioner, hospital, or health care institution to release to the Municipal Police Employees Retirement System (MPERS) any medical information, which may be required to establish the validity of this claim. I also authorize such company, person or organization to disclose any relevant claim information required for the review of this claim. I agree that a photocopy shall be as valid as the original.

I have read and understand all pages of this application and certify that, to the best of my knowledge, all information provided on this document is true and correct.

Member's Signature Date

PLEASE ATTACH COPIES OF NECESSARY MEDICAL REPORTS/RECORDS TO THIS APPLICATION.

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DISABILITY REPORT

Member's First Name	Middle Name	Last Name	Today's Date	Social Security Number

IMPORTANT: Complete the entire form. Follow the specific instructions for each section. All dates should be in MM/DD/YYYY format.

SECTION 1: INSTRUCTIONS

Please be sure to answer all questions. The form must be signed by your supervisor and certified by your employing agency. This form should be attached to the Disability Retirement Application form.

SECTION 2: TO BE COMPLETED BY YOUR IMMEDIATE SUPERVISOR

Job Title

Explain when and how the disability began to affect the performance of the applicant's duties:

Physical exertion required? ☐ Extensive ☐ Moderate ☐ Light

Lifting required? ☐ Yes ☐ No

Climbing required? ☐ Yes ☐ No

Was the disability a result of an injury or accident/incident on the job? ☐ Yes ☐ No

If yes, was the injury sustained in the official performance of official duties? ☐ Yes ☐ No

If yes, please attach a copy of the Employer's Report of Occupational Injury or Disease.

Are Worker's Compensation payments being received? ☐ Yes ☐ No

Specifically list the above stated duties that the applicant can no longer perform because of the disability:

Describe any special physical requirements:

Social Security Number

Describe the working conditions:

List specific information you have as to the date and cause of the disability:

When and how did the disability begin to affect the performance of the applicant's duties:

SECTION 3: SIGNATURE OF SUPERVISOR

Name of Supervisor | Title | Daytime Area Code/Phone Number

Signature of Supervisor | Date

SECTION 4: POLICE CHIEF'S SIGNATURE AND CERTIFICATION

Name of Police Chief | Name of Municipality

Mailing Address | City | State | Zip Code

Date on which applicant exhausted all sick & annual leave

Do you have another position in the department where the applicant can be placed in which he/she could continue to earn the same salary?

☐ Yes ☐ No

If yes, please attach a copy of the official job description.

Signature of Police Chief | Date | Daytime Area Code/Phone Number

I am not certifying whether this applicant is disabled. I am only certifying that this form was completed under my direction.

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ATTENDING PHYSICIAN'S STATEMENT FOR DISABILITY RETIREMENT

Member's First Name	Middle Name	Last Name	Today's Date	Social Security Number

IMPORTANT: Complete the entire form. Follow the specific instructions for each section. All dates should be in MM/DD/YYYY format.

SECTION 1: INSTRUCTIONS FOR PHYSICIAN

To the ATTENDING PHYSICIAN - Please attach all medical records, treatment notes, X-rays, and test results. **Failure to do so will result in delays to your patient.** Return the completed form to MPERS at the above mailing address. The purpose of this report is to assist us in making a determination of disability. In completing this report, please include sufficient detail of history, physical and diagnostic findings, clinical course, and therapy to enable us to make this determination.

SECTION 2: PATIENT INFORMATION

Height	Weight	Member's Birth Date

Did the disability occur solely as a result of injuries sustained in the performance of the applicant's official duties?

☐ Yes ☐ No

SECTION 3: DIAGNOSIS

Primary Diagnosis	ICD10 Code	ICD10 Code Description

Secondary Diagnosis	ICD10 Code	ICD10 Code Description	ICD10 Code	ICD10 Code Description

List Detailed Subjective Symptoms. If needed, please attach additional sheets with "Subjective Symptoms," the patient's name, and Social Security number at the top:

SECTION 4: TREATMENT

Date of First Visit for this Illness/Injury	Date of Last Visit

Frequency of Current Visits:

☐ Weekly ☐ Monthly ☐ Other

Social Security Number

Nature and Dates of Treatment:

SECTION 5: PROGRESS

Check one:

☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Indicate how activities are restricted:

Present Status:

☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospitalized

If hospitalized, name of hospital and dates of confinement:

SECTION 6: EFFECT OF PHYSICAL/MENTAL IMPAIRMENT ON JOB DUTIES

Explain in sufficient detail the extent that the patient's illness or injury affects their capacity to perform current job duties:

What are the patient's current functional abilities in the following areas in hours (based on an 8-hour day)?

Sitting: ☐ Continuously ☐ With Rests

Standing: ☐ Continuously ☐ With Rests

Walking: ☐ Continuously ☐ With Rests

Lifting: ☐ 1-10 lbs. ☐ 10-25 lbs. ☐ 25-50 lbs. ☐ Over 50 lbs.

Cardiac Functional Capacity (if applicable). Rate based on American Heart Association Rules:

☐ Class 1 (no limitation) ☐ Class 3 (marked limitation) ☐ Class 2 (slight limitation) ☐ Class 4 (complete limitation)

Activities:	Never	Occasionally	Frequently	No Restriction
Bending	☐	☐	☐	☐
Stooping	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Squatting	☐	☐	☐	☐
Reaching above shoulder	☐	☐	☐	☐
Driving	☐	☐	☐	☐
Blood Pressure	☐	☐	☐	☐

Social Security Number

Is the patient in a coma that was caused solely as the result of injuries sustained in the performance of his official duties?

☐ Yes ☐ No

Is the patient paraplegic due solely to injuries sustained in the performance of his official duties?

☐ Yes ☐ No

Is the patient a police officer who suffered a bilateral knee injury disability while in the discharge of his duties?

☐ Yes ☐ No

If yes, please describe the specific injuries to each knee and indicate the date of the specific on-the-job injuries to each knee. You must attach test results documenting your conclusions.

Is the patient permanently and completely confined to a wheelchair for movement of person as a result of an injury sustained in the line of duty?

☐ Yes ☐ No

Is the patient an amputee as of result of an injury sustained in the line of duty to the degree that he would be disqualified from serving as a municipal policeman?

☐ Yes ☐ No

If yes, please identify the particular body part(s) that were amputated and why you believe such amputation disqualifies the member from serving as a municipal policeman. You must attach test results documenting your conclusions.

Is the patient permanently and legally blind solely as a result of injuries suffered in the line of duty?

☐ Yes ☐ No

Has the patient lost the total use of a limb due solely to injuries sustained on or after July 1, 2003 in the performance of the patient's official duties? Total loss of use of limb means that no effective function remains other than that which would be equally served by amputation.

☐ Yes ☐ No

If yes, please identify the particular limb or limbs and describe why you believe that total loss exists. **You must attach test results documenting your conclusions.**

Social Security Number

Has the patient, due solely to injuries sustained in the performance of his or her official duties, suffered a traumatic physical injury that caused permanent damage to the brain or spinal cord? Note to applicants: This provision only affects the potential amount of disability benefit if you are NOT a subplan member.

☐ Yes ☐ No

If yes, please identify the traumatic physical injury and describe the specific damage sustained to the brain or spinal cord. You must attach test results documenting your conclusions.

SECTION 7: REMARKS AND RECOMMENDATIONS (YOU MUST ANSWER BOTH QUESTIONS)

1. In my opinion, this employee is totally and permanently incapacitated from future performance of his/her normal job duties.

☐ Yes ☐ No

2. In my opinion, this employee should be retired.

☐ Yes ☐ No

SECTION 8: ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician

Specialty/Degree

Daytime Area Code/Phone Number

Mailing Address

City

State

Zip Code

Signature of Attending Physician

Date