CT TEACHERS' RETIREMENT BOARD
765 ASYLUM AVENUE HARTFORD, CT 06105-2822
"An Affirmative Action/Equal Opportunity Employer"
Toll-Free 1-800-504-1102 (860) 241-8416 Fax (860) 622-2848 www.ct.gov/trb

APPLICATION FOR A DISABILITY ALLOWANCE

ELIGIBILITY REQUIREMENTS

- You cannot perform the duties of your assigned job, due to a physical or mental impairment.
- You are ACTIVE with your last employing Connecticut board of education, including up to ten months of a current leave of absence where mandatory contributions were remitted; purchased prior Connecticut teaching service previously withdrawn, and time while out on workers compensation provided the mandatory contributions were remitted.
- You have five years of credited service in the public schools of Connecticut, for a non-service related claim.
- You are <u>not</u> eligible to receive normal benefits. (35 years service, at least 25 years are CT service, or 20 years of CT service at age 60).

FILING REQUIREMENTS

The following items must be received before your claim will be placed on the Medical Review Committee agenda:

1) Medical Reports and office notes from your physician(s)
2) Statement from Human Resources regarding work performance and attendance records
3) Handwritten statement from you outlining the effect your illness has on your ability to perform your job duties.

Your completed application for a disability allowance is due in this office prior to the effective date of your disability allowance.

4) Application for a Disability Allowance
5) Beneficiary Designation Form.
6) Birth Certificate (Photocopy acceptable).

ELECTION OF SUPPLEMENTAL and/or VOLUNTARY ACCOUNTS

Members who were employed prior to June 1989 may have a 1% Supplemental account. Those members who paid additional monies into the system have a Voluntary Account. Your choices for distribution are:

- Refund/Rollover. Funds may be refunded directly to you, in which case, any pre-tax contributions and interest will become taxable. Alternatively, pre-tax contributions and interest may be rolled over into another "qualified plan", such as an IRA. The paperwork for the refund/rollover option will be mailed to you after the effective date of your disability allowance. Failure to return the paperwork for the refund/rollover option on a timely basis will result in your funds being refunded directly to you which may result in federal or state tax liabilities and related penalties.

- Extra Annuity. In lieu of receiving your 1% Supplemental and/or Voluntary account in a lump sum, you may elect to increase your monthly payment with an additional fixed annuity based on your account balance and age annuity rates in effect at the time of your disability effective date. These fixed payments are excluded from cost of living increases. Funds to be used for the purchase of an extra annuity must be received by the Teachers' Retirement Board no later than the effective date of your disability allowance.

CTRB DISABILITY REVIEW PROCESS

Our Medical Review Committee (panel of licensed private doctors) reviews the medical evidence and required statements. They forward a recommendation to the Teachers' Retirement Board. The Committee meets on the first Tuesday of every month (excluding August). All items to be reviewed must be received by this office no later than the 18th of the month prior to the meeting date. When the 18th of the month falls on a weekend or State holiday, the deadline becomes the first business day following the 18th. After the MRC meeting, you will receive written notification of the results of the meeting, and if approved, an Effective Date Election Form for your immediate completion.

The disability income will cease when the disability ends. The Board may call upon the member to submit periodic medical reports, and determine that a member's disability has ended if it finds that the member has failed to pursue an appropriate program of treatment.

Disability benefits will be calculated at 2% of your final salary base (average of highest three paid salaries) times the years of full-time credited service, subject to a maximum benefit of 50% of final average salary, and minimum benefit of 15% of final average salary (for 7.5 or fewer years of service). Additional Service Credit purchased within five years of the effective date of disability is excluded.

OFFSETS AGAINST INCOME WHILE COLLECTING A DISABILITY ALLOWANCE

During the first twenty-four months, twenty percent of any earned income or wages shall be subtracted from the disability allowance payable unless the Board determines that such earned income is being paid as part of the rehabilitation of the member.

After the first twenty-four months, your disability allowance and your earned income can equal the "final average salary" we used to compute your disability allowance. All earnings in excess of this amount are subtracted from your disability allowance.

A dollar for dollar offset will apply if the total of the disability allowance, less cost of living adjustments plus any initial award of social security benefits or worker's compensation, exceeds seventy-five percent of the member's final average salary.

TWENTY FOUR MONTHS LATER

After twenty four months of disability allowance payments you will be required to submit new medical documentation. To be eligible for a continued disability allowance, additional medical documentation must be provided to substantiate that you do not have the ability to engage in any substantial gainful activity.

CONVERSION OF BENEFIT

Service credit will accrue to a maximum of 30 years while receiving disability allowance. Upon the attainment of age 60 (or older) with a minimum of 20 years of CT credited service (including accrued service), the disability allowance will be converted to a normal retirement benefit. You will be required to select a payment plan and your converted benefit will include any cost of living adjustments accrued while on disability.

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APPLICATION FOR A DISABILITY ALLOWANCE

MEMBER INFORMATION:

Name of Applicant:		Date of Birth:	Social Security #:
Street Address:		City	State/zip:
Home Phone #:	Other Phone #:	Email address:	

ELECTION OF SUPPLEMENTAL and/or VOLUNTARY ACCOUNTS

Check one category for each Account you have. If in doubt, refer to your annual statement.

Account Type	Refund/Rollover*	Extra Annuity
1% Supplemental	☐	☐
Voluntary	☐	☐

***** If you elect the lump sum option, additional information will be sent to you regarding the distribution of the account(s).

LIST ALL PHYSICIANS WHO WILL BE PROVIDING MEDICAL REPORTS TO TRB. ALL REPORTS MUST BE RECEIVED BEFORE YOUR CASE WILL BE REVIEWED.

Physician's name	Address	Telephone

Under current laws and regulations, Medical insurance is available with your last employing Board of Education until you are enrolled in Medicare A and B, at which time supplemental insurance is available through Teachers' Retirement.

Certification Statement:
I understand I am required to report all earned income, Social Security and Worker's Compensation Benefits to the Teachers' Retirement Board and submit periodic medical reports when requested and that failure to comply will result in discontinuance of my disability allowance.

Applicant's Signature **Date**

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BENEFICIARY ELECTION FOR DISABILITY ALLOWANCE FORM

Section 10-183(h) of the Connecticut General Statutes requires that monthly survivor benefits be paid to the statutory survivors of members who die while active before any balance is paid to your designated beneficiary. This is true regardless of whom you designated as your beneficiary. A statutory survivor includes but is not limited to a spouse and/or a minor child under the age of 18. Refer to our **Survivorship Benefits Before Retirement Bulletin** before completing this form. This form supersedes and replaces any previous beneficiary designations. All items pertaining to beneficiaries must be completed in order for the Connecticut Teachers' Retirement Board (CTRB) to process the form; incomplete forms will be returned.

- Include a complete list of all beneficiaries.
- Type or print clearly in ink and do not use white out.
- Do not submit an amended copy of a previous beneficiary form.
- You may name any living person, your estate, a trust, or a charitable organization as your beneficiary.
- At least one primary beneficiary must be named. If more than one primary beneficiary is named, the share of any beneficiary who dies before you shall be divided equally among the surviving primary beneficiaries.
- A payment is made to a contingent beneficiary(ies) only if all primary beneficiaries die before you do.
- If you survive all of the beneficiaries named, payment would be issued to your estate.
- "Per Stirpes" designations (unnamed or unborn beneficiaries) are not accepted.
- All information must appear in the appropriate section of this form.
- To designate a trust as a beneficiary enter the name and date of the trust agreement in the Beneficiary section of this form; leave the Relationship and Social Security sections of this form blank; and indicate Primary or Contingent.
- To designate your estate as a beneficiary enter the word "Estate" in the Beneficiary section of this form; leave the Relationship and Social Security sections of the form blank; and indicate Primary or Contingent.

MEMBER NAME (First Name, Middle Initial, Last Name)	SOCIAL SECURITY #
STREET ADDRESS	E-MAIL ADDRESS
CITY, STATE, ZIP	**CHECK IF:** NEW ADDRESS ☐ NAME CHANGE ☐

BENEFICIARY NAME AND ADDRESS (include ZIP Code)	RELATIONSHIP	SOCIAL SECURITY #	CHECK ONE
Name: Address:			☐ primary ☐ contingent
Name: Address:			☐ primary ☐ contingent
Name: Address:			☐ primary ☐ contingent
Name: Address:			☐ primary ☐ contingent

Use additional Beneficiary Election for Disability Allowance forms to designate additional beneficiaries.

☐	If you have a spouse who you have not designated as a beneficiary, you need to check this box to waive the statutory survivorship benefits for your spouse in order for your designated beneficiary to receive the funds in your account in the event of your death prior to your conversion to a normal retirement benefit.

SIGNATURE OF MEMBER	DATE

CTRB does not acknowledge the receipt of individual forms. Please retain a copy of this form for your records and forward it by fax or regular mail directly to CTRB at the address above.

DisBenChg (050916)

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SURVIVORSHIP BENEFITS - SETTLEMENT INFORMATION

Active member or CTRB Disability Allowance recipient dies PRIOR to meeting retirement eligibility requirements:

Spouse?	Primary Beneficiary	Minor Children?	Settlement of Account
Yes	Spouse	Yes	Surviving Spouse Benefit and Minor Child Benefit
Yes	Other	No	Surviving Spouse Benefit
Yes	Spouse	No	Surviving Spouse Benefit or Lump Sum Payment
No	Children	Yes	Minor Child Benefit
No	Children	No	Lump Sum Payment to Beneficiary
No	Other	No	Lump Sum Payment to Beneficiary
No	Other	Yes	Minor Child Benefit

Active member or CTRB Disability Allowance recipient dies AFTER meeting retirement eligibility requirements:

Spouse ?	Primary Beneficiary	Minor Children?	Settlement of Account
Yes	Spouse	Yes	Surviving Spouse Benefit or Lump Sum Payment or Plan D 100% Co-participant Benefit plus Minor Child Payment
Yes	Other	No	Surviving Spouse Benefit or Lump Sum Payment or Plan D 100% Co-participant Benefit
Yes	Spouse	No	Surviving Spouse Benefit or Lump Sum Payment or Plan D 100% Co-participant Benefit
No	Children	Yes	Minor Child Benefit
No	Children	No	Lump Sum Payment to Beneficiary
No	Other	No	Lump Sum Payment to Beneficiary
No	Other	Yes	Minor Child Benefit

Retirement Eligibility Requirements:

- 10 years of CT credited service at age 60 or over.
- 20 years of credited service at age 55 (minimum 15 in CT).
- 25 years of credited service any age (minimum 20 in CT).
- 35 years of credited service any age (minimum 25 in CT)

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MEMBER PERSONAL STATEMENT FOR DISABILITY ALLOWANCE

You are required to submit a handwritten statement outlining the effect your illness has on your ability to perform your job duties and your day to day personal activities. Please be as specific as possible.

Name of Applicant	Social Security #
I am applying for a Disability Allowance due to: (Please check one)	A Physical Impairment ☐
	A Mental Impairment ☐
	Both a Physical and a Mental Impairment ☐

Applicant's Signature **Date**

MEMBER'S PERSONAL HANDWRITTEN STATEMENT:

You may add additional pages as necessary. Please do not write on the back of this form or on the back of any additional forms.

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PERSONAL PHYSICAN'S AUTHORIZATION FORM AND MEDICAL REPORT

This report should be provided to all of the physician's listed on your disability allowance application

Applicant's Name	
Applicant's Address	
Date of Birth	

I authorize the release of my medical information in determining whether I can be considered for a disability allowance from the Connecticut Teachers' Retirement Board.

Applicant's Signature:_____Date:_____

Physician:
Please mail or fax this medical report, including all office notes, to CTRB, 765 Asylum Avenue, Hartford, CT 06105-2822. Please do not write on the back of this form or on the back of any additional forms.

Office notes/records are required along with the following information.

1. Major Health Complaints as stated by the patient

2. Past Medical History; include hospitalizations, laboratory findings, x-rays etc.

3. Precipitating events, including accidents

4. Current history: (Please check the appropriate categories)

☐ Extremities and Back	☐ Peripheral Spinal Nerves	☐ Central Nervous System
☐ Respiratory System	☐ Cardiovascular System	☐ Hematopoietic System
☐ Visual System	☐ Ear, Nose, Throat	☐ Digestive System
☐ Reproductive/Urinary System	☐ Endocrine System	☐ Skin
☐ Mental Illness		

5. Describe Symptoms and Signs, onset and duration:

6. Abnormal Physical Findings:

7. Diagnosis and Degree of Impairment of function

8. Course of treatment, Current Treatment plan, Patient Response

9. Current Medications

10. Clear Statement Regarding "Disabled" Status

Name of Physician(Signature)/Date:	
Name of Physician(Type or Print):	
Physician's Specialty:	
Connecticut Medical License #:	

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HUMAN RESOURCE STATEMENT FOR DISABILITY ALLOWANCE

Date: _____

From: _____
Name of Applicant Social Security Number Employer

To: _____
Name of Human Resource Director

I am applying to the Connecticut Teachers' Retirement Board for Disability. I authorize you to submit a statement to Connecticut Teachers' Retirement Board. This statement should include background information such as days missed from school, any pending workers' compensation claims, any short or long term disability insurance claims.

_____

Applicant's Signature **Date**

HUMAN RESOURCE DIRECTOR: (PLEASE PROVIDE THE FOLLOWING INFORMATION)

1. Please provide the attendance records of the applicant for the past 24 months;

2. Is the applicant able to perform the essential functions of their assigned position?
☐ Yes ☐ No
If no, please provide a list of the essential functions they are unable to perform

3. Is the applicant receiving workers' compensation benefits? ☐ Yes ☐ No

4. Is the applicant receiving any board provided short or long term disability? ☐ Yes ☐ No

Signature of Human Resource Director **Date**

TO Human Resource Director:
Please complete this form and mail or FAX directly to this office. You may add additional pages as necessary. Please do not write on the back of this form or on the back of any additional forms.

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FEDERAL AND CT TAX WITHHOLDING CHANGE FORM

Complete the federal or state section if you wish to change that election. If you wish to change only one election, leave the other section blank. This change will remain in effect until we receive another form.

Print Your Name _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Email Address _____

* * * * * * * FEDERAL TAX ELECTION * * * * * * *

Please select one option below:

1. ☐ No withholding. I realize that I am liable for payment of Federal Income Tax on my Teachers' Retirement Benefit.

2. ☐ I would like to have withholding calculated based on the following marital status and withholding allowances:

   Check One: ☐ Married ☐ Single ☐ Married, but withhold at higher Single rate

   Withholding Allowances: _____
   (TRB will code zero allowances if none is specified)

   Optional for choice 2: I wish to have $_____ withheld from my monthly benefit payment in addition to the withholding based on marital status and withholding allowances. (Whole dollar amount only, percentages not acceptable)

* * * * * * * CONNECTICUT TAX ELECTION * * * * * * *

We can only withhold State taxes for the State of Connecticut. If you have any questions on your Connecticut tax obligation, contact the Department of Revenue Services at 1-800-382-9463 (in CT) or 1-860-297-5962 (from anywhere) or visit their website @ www.ct.gov/drs.

1. ☐ I elect to have $_____ withheld monthly for Connecticut Income Tax.
   (Whole dollar amount only, percentages not acceptable)

2. ☐ I elect to have **NO** Connecticut income tax withheld from my Teachers' Retirement benefit.

Member's Signature _____ **Date** _____

CTRB does not acknowledge the receipt of individual forms. CTRB must receive the completed form by the 1st of the month in order for the change to be effective at the end of the month. (Benefits for the month are issued on the last business day of that month.) We require that the net monthly amount payable to the member be at least $10 after all deductions.

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ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

I authorize the CTRB to initiate the electronic deposit of my monthly recurring benefits into my personal account at a financial institution that is a participating member of the National Clearing House Association (NACHA). I understand that this bank account must be a personal bank account and not a business, trust or other form of account.

I also understand that by electing an electronic deposit of my benefit I will get a statement from the CTRB only when my monthly net benefit changes, rather than a monthly statement. The statement will denote the change including but not limited to changes in tax deductions or health insurance premiums thereby enabling me to account for all benefit activity.

This authorization applies to all monthly payments by the CTRB including retirement benefits, survivorship benefits, and disability allowances. In the event of my death, I authorize my estate to reimburse CTRB for any amounts which I was not entitled to receive and which were deposited following my death.

MUST BE A PERSONAL BANK ACCOUNT OF THE MONTHLY BENEFIT RECIPIENT OR THE MONTHLY BENEFIT RECIPIENT'S LEGAL DESIGNEE (CONSERVATOR OR POA); MAY NOT BE A BUSINESS, TRUST, OR OTHER FORM OF ACCOUNT): PLEASE CHECK THIS BOX IF THIS IS A NEW ADDRESS ☐

Monthly Benefit Recipient's Name	Social Security Number
Street Address	Email Address
City, State, Zip	Home Phone
Monthly Benefit Recipient's Signature	Date Signed

ATTACH A VOIDED CHECK WHICH INCLUDES THE BANK NAME, ACCOUNT HOLDERS' NAME, ROUTING NUMBER, AND ACCOUNT NUMBER OR HAVE THE FINANCIAL INSTITUTION COMPLETE THE FOLLOWING:

Financial Institution must be a participating member of the National Automated Clearing House Association (NACHA).

Routing Transit Number (Not to exceed 9 digits)	Bank Account Number (Not to exceed 17 digits)

Account Holder (*must be or include Monthly Benefit Recipient's name*)	Bank Account Type (select one): Checking ☐ Savings ☐
Name of Financial Institution	
Street Address	
City, State, Zip	Phone
Signature of Bank Representative	Date Signed

☐ Check this box and sign under Monthly Benefit Recipient's signature above to decline EFT; CTRB will mail a paper check to the address on our records.

CTRB does not acknowledge the receipt of individual forms. CTRB must receive the completed form by the 1st of the month in order for the EFT to be effective at the end of the month. (Benefits for the month are issued on the last business day of that month.)

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Electronic Funds Transfer (EFT)

What is it?

Electronic Funds Transfer (EFT) is a system which electronically deposits your net benefit payment into your personal checking or statement savings account.

Why should I participate?

EFT enables the Monthly Benefit Recipients to receive their benefit payment on the last business day of each month. Because the payment is electronically deposited in your account, this eliminates the need to make a deposit in person. EFT also safeguards against theft, loss, misdirected mail and forgery.

Where can you deposit my benefit?

An EFT deposit can be made to your personal checking or statement savings account. Your bank must be a participating member of the National Automated Clearing House Association (NACHA). Most banks, savings and loan associations and credit unions participate.

What will be deposited?

Your net benefit payment will be deposited. Your gross benefit, deductions and any cost of living increases will be calculated exactly the same way.

How do I enroll for EFT deposits?

Simply fill out the upper portion of the Electronic Funds Transfer (EFT) Authorization and attach a voided check or fill out the upper portion of the form and then forward the form to an officer of your bank for completion. This completed form must then be submitted to the Teachers' Retirement Board for processing.

How long does it take to get EFT started?

If we receive the completed EFT form by the first of the month, your EFT payment will begin at the end of the month.

What happens if I change banks?

A new EFT form must be submitted.

What happens if I change my account with the same bank?

You must provide CTRB with your new account number ***in writing by the first of the month.*** The EFT deposit will be made to the new bank account at the end of the month.

Will I receive any type of notice from TRB of the EFT deposit?

You will receive a statement from this office when your EFT is initiated. You will also receive a statement when there is a financial change on your account (i.e.: taxes, cost-of-living adjustment). A statement will not be issued, however, for non-financial changes such as a bank and/or bank account number change.

Will I continue to receive correspondence, newsletters and tax information if I sign up for EFT?

Yes. All mailings will be issued to your home address on our records. As always, it is important that you keep us informed of any changes to your home address in writing.