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ICERS
IMPERIAL COUNTY EMPLOYEES' RETIREMENT SYSTEM
www.icers.info

APPLICATION FOR DISABILITY RETIREMENT

(Please print in ink and complete all pages. If a question does not apply, please indicate with N/A. If more space is required, attach additional sheets of paper.)

Type of Disability Retirement applying for (check one):

☐ **SERVICE CONNECTED DISABILITY RETIREMENT**

☐ **NON-SERVICE CONNECTED DISABILITY RETIREMENT**

Name: _____
(First) (Middle) (Last)

Other names used during County of Imperial, Superior Court, ICTC or LAFCO employment: ___
_____

Address: _____

Home Phone No: _____ Work Phone No: _____

Cell Phone No: _____ Fax No: _____

Age: _____ Sex: _____ Driver's License No: _____

Date of Birth: _____ Social Security No: _____

Date of Hire: _____ Years of Employment: _____

Currently married or registered as a domestic partner? ☐ Yes ☐ No

If Yes, Date of Marriage/Registration: _____

Spouse/Domestic Partner: Name: _____
Date of Birth: _____
Social Security No: _____

Children under 18 years of age:

Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

Position for which permanently incapacitated: _____

Department Name: _____ Name of Department Head: _____

Name of Supervisor: _____ Last Date at Work: _____

Are you willing to accept another position with the County which would not result in a loss of income to me and which I would be able to perform? ☐ Yes ☐ No

If yes, I would like to apply for Supplemental Disability Retirement as follows:

☐ Service connected salary supplement.
Government Code Section 31725.65 allows retired members with service connected disabilities to return to work, through a reemployment plan, in a new position they are capable of performing. Should the member opt to return to work in a lower paying County position, ICERS will pay the member a supplemental allowance totaling the difference between the new, lesser paying position and the previous higher paying position. Applies only to those members who were incapacitated for the performance of their duties on or after January 1, 2004, and who are eligible to retire for service connected disability.

☐ Non-Service connected salary supplement.
Government Code Section 31725.5 allows retired members with non-service connected disabilities to return to work, through a reemployment plan, in a new position they are capable of performing. Should the member opt to return to work in a lower paying County position, ICERS will pay the member a supplemental allowance totaling the difference between the new, lesser paying position and the previous higher paying position. Applies to members eligible to retire for non-service connected disability.

NOTE: If the Board of Retirement finds you are permanently incapacitated but the disability is not work related, the Board may grant a non-service connected disability retirement. You may appeal that decision. However, the Board's finding of disability will not be binding if appealed.

While awaiting a decision on a Disability Retirement application, you may be eligible for a Service Retirement allowance.

General:

- Age 50 with 10 or more years of ICERS (or combined ICERS and reciprocal system) service credit.
- At any age with 30 years of ICERS (or combined ICERS and reciprocal system) service credit.
- Age 70 regardless of years of service credit.

Safety:

- Age 50 with 10 or more years of ICERS (or combined ICERS and reciprocal system) service credit.
- At any age with 20 years of ICERS (or combined ICERS and reciprocal system) service credit.

I understand these eligibility requirements and wish to apply for the Service Retirement allowance pending the outcome of my disability retirement application.

☐ Yes ☐ No

If yes, please provide me with an estimate for retirement with an effective date of _____.

NOTE: To apply for a service retirement, you may also call an ICERS Retirement Specialist, or complete the Request for Estimate form found on the Retirement Forms page of *www.icers.info*, and mail it to ICERS.

If you are a Safety Member applying for a Service Connected Disability Retirement, you may apply for Advanced Disability Pension Payments under Labor Code Section 4850.4 if you meet certain conditions. This program is administered by the Imperial County Human Resources Department. These payments would continue until your application for disability retirement is decided.

I understand the eligibility conditions and will be applying for Advanced Disability Pension Payments with the Human Resources Department pending the outcome of my disability retirement application.

☐ Yes ☐ No

Current employment status with County of Imperial, Superior Court, ICTC or LAFCO (check all that apply):

☐ Working _____ hours per week.
☐ Sick leave with compensation. Approximate date leave ends: _____
☐ Industrial leave with compensation. Approximate date leave ends: _____
☐ Resigned or terminated from County service. Effective date: _____
☐ Receiving or have received Long-Term Disability (LTD) benefits administered by the County of Imperial, Superior Court, ICTC or LAFCO's Third Party Administrator. If so, what period did you receive LTD benefits? _____

1. Describe specifically the injury or illness causing you to be permanently disabled from performing your usual duties, including the body parts that are involved:

2. On what date were you injured or first noticed you were ill? _____

3. Where did the injury or illness occur? _____

4. How did the injury occur, or what caused the onset of the illness? _____

5. Please list all witnesses to your job-related injuries or illness. Give names, work locations, phone numbers, and addresses of the witnesses.

6. Describe **actual** duties performed at the time your disability arose. (Attach a copy of the Job Description from Human Resources)

7. State in detail the usual duties you cannot perform because of your permanent work restrictions.

8. Are you claiming your job or job environment has aggravated or accelerated a pre-existing injury or illness? ☐ Yes ☐ No

If yes, what is the nature of the pre-existing injury or illness? _____

_____

_____

_____

Give the date of the original occurrence of the injury or onset of the illness. _____

_____

9. Have you ever received treatment for a similar injury or illness? ☐ Yes ☐ No

   If yes, give the dates and types of treatment. _____

   _____

   _____

   _____

10. If you are a Safety member applying for disability under one of the following presumptions, please check the type and answer the questions under that category.

☐ Heart Presumption (Government Code Section 31720.5)

a. Are you a Safety member?	☐ Yes	☐ No
b. Do you have at least five years of service?	☐ Yes	☐ No
c. Have you developed heart trouble?	☐ Yes	☐ No
d. Are you permanently incapacitated because of this?	☐ Yes	☐ No

☐ Cancer Presumption (Government Code Section 31720.6)

a. Are you a Safety member?	☐ Yes	☐ No
b. Do you have at least five years of service?	☐ Yes	☐ No
c. Do you still work as a Safety member?	☐ Yes	☐ No
If no, when did you last work? _____ (You have 3 months for each year of service but not more than 5 years to file.)		
d. Have you developed cancer?	☐ Yes	☐ No
e. Are you permanently incapacitated because of cancer?	☐ Yes	☐ No
f. Can you show that you were exposed to a carcinogen as a result of performing your job duties?	☐ Yes	☐ No

☐ Blood Borne Infectious Disease Presumption (Government Code Section 31720.7)

a. Are you a Safety member?	☐ Yes	☐ No
b. Do you still work as a Safety member?	☐ Yes	☐ No
If no, when did you last work? _____ (You have 3 months for each year of service but not more than 5 years to file.)		
c. Have you developed a blood borne infectious disease which is a disease caused by exposure to pathogenic microorganisms that are present in human blood that can cause disease in humans?	☐ Yes	☐ No
d. Are you permanently incapacitated because of this disease?	☐ Yes	☐ No

☐ MRSA Skin Infection Presumption (Methicillin-resistant Staphylococcus aureus skin infection) (Government Code Section 31720.7)

a. Are you a Safety member? ☐ Yes ☐ No
b. Do you still work as a Safety member? ☐ Yes ☐ No
If no, has less than 90 days passed since you last worked as a safety officer? ☐ Yes ☐ No
c. Have you developed a methicillin-resistant Staphylococcus aureus skin infection? ☐ Yes ☐ No
d. Are you permanently incapacitated because of this disease? ☐ Yes ☐ No

☐ Biochemical Substance Presumption (Government Code Section 31720.9)

a. Are you a Safety member? ☐ Yes ☐ No
b. Do you still work as a Safety member? ☐ Yes ☐ No
If no, when did you last work? _____
(You have 3 months for each year of service but not more than 5 years to file.)
c. Did you become ill (or die if you are applying on behalf of someone else) because of exposure to a biochemical substance defined as a biological or chemical agent that may be used as a weapon of mass destruction, including any chemical warfare agent, weaponized biological agent or nuclear or radiological agent? ☐ Yes ☐ No
d. Are you permanently incapacitated because of this? ☐ Yes ☐ No

11. Are you presently self-employed or employed by anyone other than the County?
☐ Yes ☐ No

If yes, list employer's name, address, telephone number, as well as your job duties and hours. _____

12. List all employers (including other County departments) for whom you have worked in the last 10 years. Include addresses, telephone numbers, and periods of employment.

13. List the names, addresses, and telephone numbers of all doctors or other service providers consulted for your present injury or illness and similar injuries or illnesses in the past. Include approximate dates, if known. Please list the dates of any future appointments related to your injury or illness. (Add additional page if necessary.) _____

14. Have you ever received disability benefits, Workers' Compensation awards, disability pensions, or any other compensation for this or another injury or illness through the County or previous employer? ☐ Yes ☐ No

    If yes, give details. _____

15. Include any information you wish the Board of Retirement to consider in determining your disability. _____

16. Generally, a disability retirement, once granted, becomes effective on the day the application is filed, or the day following the last day of regular compensation, whichever is later. "Regular compensation" includes sick and vacation pay, and for purposes of this determination, Labor Code section 4850 pay. It does not include long-term disability (LTD) benefits. However, you may be entitled to have your disability retirement begin earlier if you delayed in filing your application and that delay was due to administrative oversight or the inability to determine your disability was permanent.

    ☐ If you are still receiving regular compensation, check this box and proceed to Number 17.

    ☐ Check this box if you are applying to have your disability allowance become effective earlier than the date this application is filed. Check the reason for this requested adjustment:

        ☐ Administrative oversight.
        ☐ At the time I left work, the permanence of my disability could not be determined.

        WARNING: Failure to complete this section will constitute the waiver of the right to apply for an earlier effective date unless (1) you amend your application prior to the date you are referred to a ICERS appointed physician for an examination, or (2) you amend this application at a later date by showing good cause for an amendment in accordance with Article 7, Section 22 of the Disability Policies and Procedures adopted by the Board of Retirement.

17. Have you retained an attorney to represent you in this disability retirement application process? ☐ Yes ☐ No

    If yes, please provide the following information:

Attorney's Name: _____
Firm Name: _____
Address: _____
Phone No: _____

NOTE: The disability retirement application process is a separate matter from Workers' Compensation. Therefore, your Workers' Compensation attorney may not represent you. If you wish to have legal representation, you must arrange for it.

18. Does your permanent incapacity described by this application involve any of the following? (Please check all that apply)

- ☐ Use of alcohol
- ☐ Use of drugs
- ☐ Willful misconduct
- ☐ Violation of the law
- ☐ Conviction of a felony
- ☐ Criminal activity

If you checked any of the boxes above, please describe in detail how the activity is connected to your permanent incapacity, the results of the activity and the date or period of time in which such activity occurred. _____

_____

_____

_____

I declare under penalty of perjury, that to the best of my knowledge the foregoing is true and correct.

Executed on _____ in _____, California.
(Date) (City)

_____
Applicant's Signature*

_____ _____
Title* Phone No.*

(* If there is a Power of Attorney or guardianship for the employee, please attach a copy.)

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MISSED MEDICAL APPOINTMENT

As provided in California Government Code Section 31723, upon determination that a medical examination is necessary, ICERS may order such an examination to determine the existence of the disability. At ICERS' expense, a medical appointment will be scheduled with a physician selected by ICERS. You will be notified by letter of the selected physician's name, address, telephone number, and the day and time of the appointment. Should you fail to keep this appointment without 48 hours advance notice to both the disability retirement section and the physician, you will be billed the physician's charges.

I understand it is my duty to contact the Disability Retirement Services Division of ICERS and the selected physician if I am unable to keep the medical appointment so ordered. If I fail to do so, the cost of the missed medical appointment is my responsibility.

Date: _____ _____

Applicant's Signature

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AUTHORIZATION TO OBTAIN AND RELEASE RECORDS AND INFORMATION

I hereby authorize the Imperial County Employees' Retirement System (ICERS) to procure and have in its possession any and all medical and psychological information.

I understand this includes, but is not limited to hospital and other records; test results including x-rays, HIV test(s), and lab reports; medical and psychological records, notes, and reports; and records and/or results from any providers of services. This also includes any and all records pertaining to alcohol and/or substance abuse treatment.

I hereby authorize ICERS to procure any and all information, including sealed and unsealed documents in the personnel file, payroll and other records, reports, and/or items concerning my employment.

I hereby authorize ICERS to procure police and/or other reports concerning any incident in which I have been involved.

I acknowledge a photocopy of this document shall be as valid as the original.

I understand this Authorization shall remain valid until the determination of my request for a disability retirement.

I understand I may receive a copy of this Authorization at any time.

I understand I may revoke this Authorization by filing a written revocation with ICERS' Disability Retirement Department. I understand by revoking this Authorization, my Disability Application will be subject to rejection.

I understand information provided to ICERS may be subject to redisclosure and ICERS cannot guarantee its protection.

I understand ICERS is materially relying on the information provided pursuant to this Authorization.

Name	Signature
Social Security No.	Date

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CLAIMS AGAINST THIRD PARTIES

Please read the entire form then complete either Section 1 or 2, whichever applies, and complete Section 3.

SECTION 1:

I certify that my disability is not a result of, or caused by, or connected to, in any manner, an injury or illness that involves a third party (i.e., someone or an organization other than your County of Imperial, Superior Court, ICTC or LAFCO employer).

_____ Please initial here and complete Section 3.

SECTION 2:

If your disability involves a third party, please provide the following information:

Name of Third Party: _____
Address: _____
City, State & Zip Code: _____
Telephone No. _____

Description of how the injury or illness occurred, including third party's involvement.

_____
_____
_____
_____
_____

Did you file a claim of any type against the third party named above?

☐ Yes ☐ No

Case Name: _____ Case No: _____ Date Filed: _____

If No, do you plan to file a claim in the future?

☐ Yes ☐ No

If No, please state why?

_____
_____
_____

SECTION 3:

I, the undersigned, agree to notify ICERS if I file any type of claim against a third party, whether or not named above, for my injury or illness.

_____ _____
Name Signature

_____ _____
Social Security No. Date