APPLICATION FOR DISABILITY RETIREMENT

VIRGINIA RETIREMENT SYSTEM
P.O. Box 2500 ◆ Richmond, VA 23218-2500
Toll-free 1-888-827-3847
Fax 804-786-9718
www.varetire.org

Clear Form

1. Social Security Number	
2. Retirement Date	
3. Check One ❑ Original Application ❑ Revised Application	

PART A. MEMBER INFORMATION

4. Name (First, Middle Initial, Last)

5. Address (Street, City, State and ZIP+4)

6. Are you a Virginia resident? ❑ Yes ❑ No

7. U.S. Citizenship
❑ U.S. Citizen ❑ Resident Alien
❑ Non-resident Alien (Marking this box certifies your status as non-resident alien and that you are not a U.S. citizen or resident alien.)

8. Marital Status
❑ Never Married ❑ Married or Separated ❑ Widowed ❑ Divorced – Date of Divorce _____ (mm/dd/yyyy)

9. Phone Number	**10. Birth Date** (mm/dd/yy)	**11. Email Address**

12. Are you in the process of purchasing prior service or have you purchased prior service credit in the past? ❑ Yes ❑ No

13. Will you be purchasing service credit with a sick leave payment? *(Irrevocable option)* ❑ Yes ❑ No

14. Is your disability application for a cause compensable under the Workers' Compensation Act? ❑ Yes ❑ No
(If yes, attach a copy of the accident report)

15. Have you received Workers' Compensation benefits? ❑ No ❑ Yes (If yes, attach a copy of the decision/award notice)

16. Have you applied for Social Security disability benefits? ❑ No ❑ Yes (If yes, attach a copy of the receipt/decision letter)

17. Will you be terminating all full-time and part-time employment eligible for coverage under VRS, including employment covered by an optional retirement plan, as well as terminating any part-time employment not eligible for coverage under VRS with the employer from which you are retiring as of your retirement date? *(See instructions for more information)* ❑ Yes ❑ No

18. SSN

PART B. PAYOUT OPTION SELECTION

19. Retirement Payout Options (Choose One)

❑ Basic Benefit

❑ Survivor Option with _____ % payable to my survivor

PART C. SURVIVOR INFORMATION

Your survivor is the person to whom your monthly retirement benefit will continue upon your death. (This is different than naming a beneficiary on the VRS-2.)

20. Survivor's Name (First, Middle Initial, Last)

21. Relationship

❑ Spouse ❑ Other

22. Survivor's Birth Date (mm/dd/yy)

23. Survivor's SSN

24. Survivor's Gender

❑ Male ❑ Female

25. Survivor's U.S. Citizenship

❑ U.S. Citizen ❑ Resident Alien ❑ Non-resident Alien (Marking this box certifies your status as non-resident alien and that you are not a U.S. citizen or resident alien)

PART D. CERTIFICATION

Member Certification

I hereby certify all information I provide in this document is true and I understand that any willful falsification of facts presented may result in prosecution as provided by law. I agree that, in the event that VRS pays retirement benefits in excess of those to which I am entitled, I or my estate will repay the excess to VRS. By signing this form, I hereby assign to VRS any VRS group life insurance benefits that may be payable as a result of my death to secure repayment of any such retirement benefit overpayment.

Member Signature _____ Date _____

Spouse Certification (Required if married or separated)

I have read and understand the retirement payout options available under VRS. I am aware of and understand the retirement payout option selected by my spouse and if my spouse chose a Survivor Option, the survivor benefits will be provided to the person named in Part C. Further, I am aware that counseling regarding the payout options is available.

Spouse's Signature _____ Date _____

Address (If different from member's address) _____

Informed Consent and Authorization

SSN

Notice to Member.

Your address, birth date, marital status, and similar information as well as your medical information are classified as private data. VRS will not share your private data with any person or entity except pursuant to your Authorization, below, or an order from a court. If you do not provide the information requested by VRS and its claim manager, Managed Medical Review Organization, Inc. (MMRO), you may impede processing of your claim.

A photocopy or facsimile of this Informed Consent and Authorization shall be as valid as the original.

Authorization for VRS and MMRO to release information.

I give my informed consent to and authorize VRS and its third-party administrator, MMRO, to provide the information in my VRS disability retirement application file, disability recall or my Line of Duty Act (LODA) claim file, as applicable, to any independent medical examiners, consultants or fact finders retained by VRS or MMRO to assist in evaluation of my application for disability retirement or LODA claim as applicable, my attorney or other authorized agent (if applicable, attorney or agent's name_____), court reporter, or a court of competent jurisdiction for the purpose of evaluating my disability retirement application, disability recall status or my LODA claim as applicable, and any appeals thereof. This Authorization shall become effective on the date appearing next to my signature below. This consent will remain effective until the evaluation of my disability retirement application, disability recall or LODA claim and any appeals thereof are complete. I understand that I may request a copy of this Authorization. I understand I have the right to revoke this Authorization at any time by notifying MMRO in writing. I understand that revoking this Authorization may impede the processing of my application for disability retirement benefits, disability recall or LODA claim.

HIPAA Authorization for care providers and consultants to release information to VRS and MMRO.

I hereby authorize the use and disclosure of protected health information about me as described below.

i. The following specific person/class of person/facility is authorized to disclose information about me to VRS, MMRO, and my attorney or authorized agent (if applicable): any health care provider, hospital, medical facility, rehabilitation consultant, or agency, or other organization.

ii. The following person, class of persons, or entity may receive disclosure of protected health information about me: VRS, MMRO and any independent medical examiners, consultants or fact finders retained by VRS or MMRO to assist in evaluation of my application for disability retirement benefits, disability recall or LODA claim.

iii. The following information may be disclosed: all information with respect to any physical or mental condition and/or treatment of me, including information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse and mental health.

iv. I understand that the information used or disclosed may be subject to re-disclosure by VRS and MMRO as necessary to evaluate my application for disability retirement benefits or LODA claim and to conduct an informal fact-finding proceeding, or judicial review of a case decision under the Virginia Administrative Process Act, and would then no longer be protected by federal privacy regulations.

v. I may revoke this authorization by notifying MMRO in writing of my desire to revoke it. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

vi. My purpose/use of the information is for my application for VRS disability retirement benefits, disability recall or LODA claim.

vii. This authorization expires one year from the date of my signature or upon the final determination of my eligibility for VRS disability retirement benefits, disability recall or LODA benefits, whichever is later.

Member's Printed Name and Signature _____ Date _____

Managed Medical Review Organization, Inc.
44090 W. 12 Mile Road, Novi, MI 48377
Telephone: 866-516-6676 Fax: 248-530-7411

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR DISABILITY RETIREMENT AND ASSOCIATED DOCUMENTS

Please read the Disability Retirement Handbook for Members located at www.varetire.org/publications before completing this application. Use myVRS on the VRS website to estimate your VRS benefits before applying for retirement.

It is important to provide all required documents at the time of application. If all required documents are not received, VRS is unable to submit your file to the Medical Review Board. This will delay a determination in your disability case and may affect when your first benefit payment is made.

Considerations:

At the time of retirement or upon receiving approval for disability retirement (whichever is earliest), you must terminate all full-time and part-time positions that are covered by VRS in order to receive a monthly retirement benefit. You must also terminate work in any part-time positions not covered under VRS for the employer from which you are retiring. If you return to work in a full-time position with any employer participating in VRS, your monthly retirement benefit must cease. You once again become an active VRS member.

If you plan to return to work in a part-time position with any employer participating in VRS:

- The duties of your new position cannot be similar to the duties of the position from which you retired, and
- Your employer must comply with Internal Revenue Service (IRS) rules about in-service distributions. For your employer to be in compliance, you must terminate all full-time and part-time employment with your current employer before you receive your benefit payment. In addition, you must incur a break in service of at least one full calendar month before returning to part-time employment in a position not covered by VRS with your current employer. This break must occur during a normal work period.

Note: State agencies are considered one employer. Retired state employees may return to work in part-time positions with other state agencies after a full calendar month break in service during a normal work period.

Completing the Application for Disability Retirement

Part A. Member Information

Boxes 1-11: Enter your personal information. In Box 2, enter the date you plan to retire (the first of any given month after your employment is terminated). If you leave this box blank, VRS will coordinate with your employer to arrange for the first possible retirement date

In Box 3, check whether this is your original application or if you are submitting a revised application.

Box 12: If you check yes, the purchase must be completed while you are actively employed and no later than your date of termination.

Box 13: If you check yes, be sure your employer has completed the online certification for your accumulated sick leave using myVRS Navigator. This option is irrevocable and cannot be reversed.

Box 17: At the time of retirement or upon receiving approval for disability retirement (whichever is earliest), you must terminate all full-time and part-time positions that are covered by VRS to receive a monthly retirement benefit. You must also terminate work in any part-time positions not covered under VRS for the employer from which you are retiring. Choose yes or no as appropriate.

Part B. Payout Option

Choose one payout option. Refer to your Disability Retirement Handbook for Members to determine which option will meet your retirement goal.

Part C. Survivor Information

Complete Part C *only* if you chose the survivor option in Part B.

Part D. Certification

Sign and date the application.

If you are unable to sign the application and you selected the Survivor Option in Part B, only an individual specifically authorized to make testamentary changes on your behalf may sign it. Authorized individuals include: a court-appointed Guardian or Committee; an Attorney-in-Fact named in a Durable Power of Attorney; or an individual specifically authorized by a court order to do so. A copy of the document providing such authorization must be presented to VRS for review before this application can be processed. If the application is not signed and dated, it is not valid and a new one must be completed. This may delay you first payment.

If you checked Married or Separated in Part A, your spouse must complete the Spouse Certification section, signing and dating the application on or after the date you sign; otherwise, a new application must be completed. If you are unable to obtain your spouse's signature, contact VRS for additional information.

Informed Consent and Authorization

Enter your SSN, print and sign your name, and date the authorization. Include it with the application when sending to VRS. This form authorizes Managed Medical Review Organization (MMRO), the VRS Medical Board, to have access to your application and supporting documents for purposes of medical review.

Completing the Other Required Documents

In addition to the Application for Disability Retirement (VRS-6), the following forms must also be completed and submitted to VRS before your application can be processed. These forms include:

Explanation of Disability (VRS-6A): Complete this form to provide your interpretation of your job duties and how you are unable to perform them. You will enter information about yourself, about your employment and about your medical conditions and any treatments you have completed.

Physician's Report (VRS-6B): This form allows your physician to provide VRS with information about your condition. Give this form to your physician and ask that it be completed and submitted directly to VRS. The physician must also submit written diagnostic, objective findings to substantiate the diagnosis.

It is in your interest to choose an authorized medical professional who will cooperate with the VRS disability retirement process to the fullest. It is your physician's responsibility to do his or her best to fully document your illness so that the Medical Board understands how your illness impacts your job performance. The Medical Board will not evaluate you personally. Your physician's documentation may have an impact on whether or not your application is approved.

Note: You are responsible for your medical bills. Remember that VRS is not responsible for payment of fees to the physician for providing any medical information.

Employer Certification and Information for Disability Application (VRS-6D): The form must be completed by your employer to provide VRS information about your position.

IMPORTANT NOTE: VRS will notify your employer when your application is received. Your employer will certify your separation from employment online.