Please read this information carefully. If you have specific questions, contact PSRSSTL as shown above.

To begin the application process for disability pension benefits, you must provide the following forms and information to PSRSSTL. Forms must be completed, signed and dated. If you are mailing information to PSRSSTL, please make copies for your records.

- Disability Pension Application
- Physician Report of Disabling Condition Form or evidence that you have been approved for disability benefits under the federal Old Age, Survivors and Disability Insurance System of the Social Security Act (SSDI Benefits).

Your disability pension must be approved by the Board of Trustees.

If your application for disability pension benefits is approved, the effective date of your disability pension will be the later of the first of the month following 15 days after your completed Disability Pension Application was received by PSRSSTL or the first of the month following the last day for which you received compensation from your employer. To be considered complete, all sections of the Disability Pension Application must be filled out, signed and dated. We must receive all necessary information and completed forms prior to determining a disability pension effective date.

The amount of your disability pension benefit will be the greater of (1) what your normal retirement benefit would be (computed as if you were age 65), or (2) one-fourth (¼) of your average final compensation; however, your disability pension benefit cannot exceed the retirement benefit you would have received at your Normal Retirement Age if you had continued to work until then.

Unless you have qualified for SSDI Benefits, the PSRSSTL Medical Board must certify (1) that you are mentally or physically disabled from performing your job, (2) that your disability is likely to be permanent, and (3) that you should be retired. If the Medical Board is not able to make a determination regarding your disability from written reports, you may be asked to undergo a hands-on physical examination. The opinion of the Medical Board will be final and conclusive.

You will be required to re-certify your disability status and demonstrate that you satisfy certain limitations on your earnings annually for the first five years of your disability pension and every three years thereafter until such time as you would have become eligible for Normal Pension had you continued to work. This re-certification process will include submitting a Physician's Statement and verification of your income. Copies of your income tax returns and supporting documentation such as W2 and 1099 Forms will be required.
### SECTION 1. PERSONAL INFORMATION

<table>
<thead>
<tr>
<th>YOUR NAME</th>
<th>SEX</th>
<th>MARITAL STATUS</th>
<th>JOB TITLE</th>
<th>WORKPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STREET ADDRESS</td>
<td></td>
<td>CITY/STATE/ZIP</td>
<td>PERSONNEL NUMBER</td>
<td>AGE AT RETIREMENT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOC SEC NO.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMPLOYMENT TYPE</td>
<td></td>
<td></td>
<td>___6 MONTH</td>
<td>___18 MONTH</td>
</tr>
</tbody>
</table>

### SECTION 2. APPLICATION FOR PENSION BENEFITS

If your application for disability is approved, your disability pension effective date will be the later of the first day of the month following fifteen days after the date your application was received by PSRSTL or the first day of the month following the last day for which you received pay.

ENTER THE LAST DAY FOR WHICH YOU EXPECT TO BE PAID BY YOUR EMPLOYER (include salary, sick leave, etc.)

X

Year Signature

### SECTION 3. BENEFIT PAYMENT OPTIONS

**I DO NOT ELECT A BENEFIT PAYMENT OPTION.** IF YOU CHECK THIS BOX, YOU MUST SIGN AND DATE BELOW AND INITIAL HERE.

**I DO ELECT A BENEFIT PAYMENT OPTION.** I UNDERSTAND THAT IF I ELECT TO RECEIVE MY PENSION BENEFITS UNDER ONE OF THE SURVIVOR PAYMENT OPTIONS DESCRIBED BELOW MY BENEFIT WILL BE REDUCED IN ORDER TO PROVIDE MONTHLY PAYMENTS TO MY OPTION BENEFICIARY AFTER MY DEATH. I UNDERSTAND THAT I MAY NOT CHANGE MY PAYMENT OPTION OR MY OPTION BENEFICIARY AFTER MY PENSION BENEFIT PAYMENT DESIGN. I ALSO UNDERSTAND THAT IF I SELECT ONE OF THE SURVIVOR PAYMENT OPTIONS BELOW, I MUST PROVIDE PSRSTL WITH A COPY OF THE BIRTH CERTIFICATE AND SOCIAL SECURITY CARD OF MY OPTION BENEFICIARY AT LEAST 15 DAYS PRIOR TO MY PENSION EFFECTIVE DATE.

(Place a check mark in the appropriate box to indicate the Payment Option you are electing. Provide Option Beneficiary information and sign and date below.)

- **Option 1** If the Option Beneficiary I have designated below is still living at the time of my death, my reduced monthly benefit payments shall continue to my Option Beneficiary on a monthly basis for her/his lifetime.

- **Option 2** If the Option Beneficiary I have designated below is still living at the time of my death, half of the amount of my reduced monthly benefit payments shall continue to my Option Beneficiary on a monthly basis for her/his lifetime.

- **Option 3** The same as Option 1, except that, if my Option Beneficiary dies before I do, effective the first day of the month following my Option Beneficiary’s death, my reduced monthly benefit will be increased to the amount I would have received at the time of my retirement had I not elected this Benefit Payment Option.

- **Option 4** The same as Option 2, except that, if my Option Beneficiary dies before I do, effective the first day of the month following my Option Beneficiary’s death, my reduced monthly benefit will be increased to the amount I would have received at the time of my retirement had I not elected this Benefit Payment Option.

- **Option 5** My monthly benefit prior to age 62 shall be increased so that my pension prior to age 62 shall be approximately equal to the sum of my pension after age 62 plus my estimated federal Social Security benefit.

- **Option 6** My monthly benefit shall be a combination of Benefit Payment Option 1 and Benefit Payment Option 5.

- **Option 7** My monthly benefit shall be a combination of Benefit Payment Option 2 and Benefit Payment Option 5.

<table>
<thead>
<tr>
<th>Name of Option Beneficiary</th>
<th>Option Beneficiary’s Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Option Beneficiary’s Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Option Beneficiary: Street Address, City, State, Zip Code</th>
</tr>
</thead>
</table>

X

Year Signature

Over, please

DUES APPLIED: 10/01

OFFICERS ONLY: ELIGIBILITY DETERMINED: VERIFIED: TO INS DEPT:
**SECTION 4. BENEFICIARY DESIGNATION**

COMPLETED THIS SECTION 4 EVEN IF YOU NAMED AN OPTION BENEFICIARY IN SECTION 3. IF YOU ELECTED A SURVIVOR BENEFIT PAYMENT OPTION AND NAMED AN OPTION BENEFICIARY IN SECTION 3, YOU SHOULD DESIGNATE A DIFFERENT BENEFICIARY(IES) IN THIS SECTION 4.

If I die (or if my Option Beneficiary and I both die) before the sum total of pension benefits which have been paid equals or exceeds my contributions to PSRSSTL, plus accumulated interest thereon, the difference will be paid to the Primary Beneficiary(ies) named below; however, if my Primary Beneficiary(ies) is not living, the difference will be paid to the Contingent Beneficiary(ies) named below.

<table>
<thead>
<tr>
<th>Primary Beneficiary(ies)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Primary Beneficiary</td>
<td>Relationship</td>
</tr>
<tr>
<td>Street Address, City, State, Zip Code</td>
<td></td>
</tr>
<tr>
<td>Name of Primary Beneficiary</td>
<td>Relationship</td>
</tr>
<tr>
<td>Street Address, City, State, Zip Code</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contingent Beneficiary(ies)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Contingent Beneficiary</td>
<td>Relationship</td>
</tr>
<tr>
<td>Street Address, City, State, Zip Code</td>
<td></td>
</tr>
<tr>
<td>Name of Contingent Beneficiary</td>
<td>Relationship</td>
</tr>
<tr>
<td>Street Address, City, State, Zip Code</td>
<td></td>
</tr>
</tbody>
</table>

DIS.PEN.APPL.2004-12-01

**SECTION 5. HEALTH CARE INSURANCE INFORMATION**

INDICATE BELOW IF YOU WISH TO ENROLL FOR MEDICAL, DENTAL AND/OR VISION INSURANCE. YOU MAY ONLY ENROLL FOR PSRSSTL-SPONSORED INSURANCE: (1) UPON YOUR RETIREMENT, (2) DURING THE OPEN ENROLLMENT PERIOD IMMEDIATELY FOLLOWING YOUR ELIGIBILITY FOR MEDICARE, OR (3) WITHIN THIRTY DAYS OF YOUR INVOLUNTARY LOSS OF OTHER GROUP COVERAGE.

Enrollment forms and benefit information about the insurance programs you indicate below will be mailed to you under separate cover. Complete the appropriate insurance enrollment forms and return them to PSRSSTL within ten days of filing your Pension Application. If you do not wish to enroll for insurance at the time of your retirement because you have other group coverage, complete and return a Waiver Form to PSRSSTL within ten days of filing your Pension Application.

**Medical Insurance**

I wish to enroll for medical insurance effective with my retirement.  

As of your retirement date, will you or any of the dependents you wish to enroll for medical insurance be entitled to Medicare insurance benefits due to age or disability status with the Social Security Administration? If yes, contact PSRSSTL immediately. Medicare-entitled members and dependents must have both Part A and Part B coverage to be eligible to enroll for PSRSSTL insurance.

Provide the name of the medical plan under which you are currently covered through St. Louis Public Schools.

**Dental Insurance**

I wish to enroll for dental insurance effective with my retirement.

**Vision Insurance**

I wish to enroll for vision insurance effective with my retirement.

**Your Signature**

Your Signature
PHYSICIAN REPORT OF DISABLING CONDITION

Instructions: Except for required signatures, type or print in ink. Member/patient should complete Sections I and II. Treating physician should complete Sections III and IV. Return completed form to PSRSSTL at the address above.

SECTION I - MEMBER/PATIENT INFORMATION

NAME

STREET ADDRESS

CITY/STATE/ZIP

SOC. SEC. NO. BIRTH DATE AGE

JOB TITLE DEPARTMENT

WORK PHONE HOME PHONE

SECTION II - MEMBER/PATIENT AUTHORIZATION TO RELEASE INFORMATION/RECORDS

I HEREBY AUTHORIZE THE PHYSICIAN COMPLETING THIS FORM TO RELEASE ANY AND ALL INFORMATION ABOUT MY DISABLING CONDITION TO PSRSSTL FOR THE PURPOSE OF COMPLETING MY APPLICATION FOR DISABILITY PENSION.

Member/Patient Signature Date of Signature

SECTION III - PHYSICIAN'S REPORT OF PATIENT'S DISABLING CONDITION

1. History
   A. When did symptoms first appear or accident happen? Mo _____ Day _____ Year ___________
   B. When did patient become unable to work due to condition? Mo _____ Day _____ Year ___________

2. Diagnosis
   A. Diagnosis (include any complications)

   ________________________________

   ________________________________

   ________________________________

   B. Subjective Symptoms

   ________________________________

   ________________________________

   ________________________________

   C. Objective Findings (include clinical findings and results of diagnostic tests)

   ________________________________

   ________________________________

   ________________________________

3. Dates of Treatment
   A. Date you first saw patient for the disabling condition Mo _____ Day _____ Year ___________
   B. Date you began treating patient for the disabling condition Mo _____ Day _____ Year ___________
   C. Date you last saw patient for the disabling condition Mo _____ Day _____ Year ___________
   D. Frequency of treatment

   [ ] Weekly
   [ ] Monthly
   [ ] Other ________________________________
SECTION III - PHYSICIAN'S REPORT OF PATIENT'S DISABLING CONDITION (continued)

4. Progress
A. Patient ☐ Has Recovered ☐ Is Improving ☐ Is Unchanged ☐ Has Regressed
B. Patient is ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospitalized
C. Has patient been hospitalized? ☐ Yes ☐ No
   If yes, confined (enter dates) from through

5. Describe Nature of Treatment (include surgery and medications prescribed)

6. Cardiac Information (if applicable)
   A. Describe functional capacity
   B. Blood pressure at last visit

7. Physical Impairment (as defined in the federal dictionary of occupational titles)
   ☐ Class 1 No Limitation, capable of heavy work (0 - 10%)
   ☐ Class 2 Medium Manual Activity (15 - 30%)
   ☐ Class 3 Slight Limitation, capable of light work (35 - 55%)
   ☐ Class 4 Moderate Limitation, capable of sedentary activity (60 - 70%)
   ☐ Class 5 Severe Limitation, incapable of minimal activity (75 - 100%)

8. Mental/Nervous Impairment (if applicable)
   ☐ No Limitations, patient is able to function under stress and engage in interpersonal relations.
   ☐ Slight Limitations, patient is able to function under most stressful situations and may engage in limited interpersonal relations.
   ☐ Moderate Limitations, patient is able to engage in only limited stressful situations and interpersonal relations.
   ☐ Marked Limitations, patient is not able to engage in stressful situations or interpersonal relations.
   ☐ Severe Limitations, patient has significant loss of psychological, physiological, personal and social adjustment.

9. Prognosis (Please answer these questions with respect to patient's current job. If a description of the patient's job duties will assist you in completing Question 9, contact PSRSSTL at (314) 241-7763.)
   A. Is patient now disabled from performing his/her job? ☐ Yes ☐ No
   B. If not now disabled, when was patient able to resume work? (Please enter date)
   C. If currently disabled, what duties of his/her job is the patient incapable of performing?

D. When will patient recover sufficiently to perform his/her job duties?
   ☐ 1 Month ☐ 1-3 Months ☐ 3-6 Months ☐ Probably Never

10. Comments/Remarks

SECTION IV - PHYSICIAN INFORMATION

Name of Physician (please print) Telephone Number Specialty or Degree
Street Address City, State, Zip
Signature of Physician Date of Signature
### SECTION 6. MEMBER STATEMENT OF DISABLING CONDITION

Except for your signature, type or print in ink. Describe your disabling condition and how the condition affects your ability to perform your job. Provide adequate detail. If you need additional space, attach additional sheets. Return this Application with the Physician Report of Disabling Condition or a copy of your award letter for disability benefits from the Social Security Administration to the Public School Retirement System of the City of St. Louis.

A. Describe the nature of your disabling condition and when it began.

---

B. Describe your job duties and how your disabling condition affects your ability to perform your job.

---

C. Provide the following information for the primary physician who is treating you for the disabling condition.

<table>
<thead>
<tr>
<th>Name of Physician</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Street Address of Physician</td>
<td>Specialty or Degree</td>
</tr>
<tr>
<td>City, State, Zip</td>
<td></td>
</tr>
</tbody>
</table>

I understand that my Application for Disability Pension will not be submitted to the Board of Trustees for approval until all required information, including a favorable Medical Board recommendation, has been received by PSRSSTL. I also understand that the Medical Board may need to perform a hands-on physical to render a recommendation.

**X** Your Signature **X** Date of Signature

D. If applicable, list below additional physicians who are treating you for the disabling condition.

---

<table>
<thead>
<tr>
<th>Name of Physician</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address of Physician</td>
<td>Specialty or Degree</td>
</tr>
<tr>
<td>City, State, Zip</td>
<td></td>
</tr>
<tr>
<td>Name of Physician</td>
<td>Telephone Number</td>
</tr>
<tr>
<td>Street Address of Physician</td>
<td>Specialty or Degree</td>
</tr>
<tr>
<td>City, State, Zip</td>
<td></td>
</tr>
<tr>
<td>Name of Physician</td>
<td>Telephone Number</td>
</tr>
<tr>
<td>Street Address of Physician</td>
<td>Specialty or Degree</td>
</tr>
<tr>
<td>City, State, Zip</td>
<td></td>
</tr>
</tbody>
</table>