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| **18000-****{stdMbrPERSLinkID}**   |  |  | | --- | --- | | **{SFNLogo}** | **APPLICATION FOR DISABILITY RETIREMENT**  NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM  SFN 18000 (Rev. 01-2014)  **{SFNAddress}** |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **PART A PARTICIPANT IDENTIFICATION** | | | | | | | | | | | | | Name (Last, First, Middle) **{stdMbrFullNameLFM}** | | | | | | NDPERS Member ID **{stdMbrPERSLinkID}** | | | | | | | Last Four Digits of Social Security Number **{stdMbrLastFourDigitsOfSSN}** | | | | | | Date of Birth **{stdMbrDateOfBirth}** | | | | | | | Organization Name **{stdCurrentEmployerOrgName}** | | | | | | NDPERS Organization ID **{stdCurrentEmployerOrgCodeID}** | | | | | | | Daytime Telephone Number | | | | | | | | | | | | | PART B OTHER BENEFITS | | | | | | | | | | | | | Are you eligible to receive the following benefits? Please check and complete the appropriate boxes. | | | | | | | | | | | | | YES | NO | BENEFITS | | | Date Benefits Began | | Date Benefits Terminate | | Amount | Paid Weekly | Paid Monthly | |  |  | Workers Compensation Benefits? | | |  | |  | |  |  |  | |  |  | Unemployment Compensation Disability? | | |  | |  | |  |  |  | |  |  | Sick Pay? | | |  | |  | |  |  |  | |  |  | Social Security Benefits? | | |  | |  | |  |  |  | |  |  | Retirement Income (Current or Past Employers?) | | |  | |  | |  |  |  | | Has Social Security Been Applied For?  Yes  No | | | | Has Worker’s Compensation Benefits Been Applied For?  Yes  No | | | | | | | | | PART C APPLICATION FOR DISABILITY BENEFITS | | | | | | | | | | | | | **SECTION 1 RETIREMENT PAYMENT OPTION (Check One)** | | | | | | | | | | | | | **MainSystem, Law Enforcement, or National Guard** | | | **Highway Patrol or Judges** | | | | | **Defined Contribution Plan** | | | | | Single Life  50% Joint Survivor/Life  100% Joint Survivor/Life  10 Year Term Certain/Life  20 Year Term Certain/Life | | | Normal Retirement  100% Joint Survivor/Life  10 Year Term Certain/Life  20 Year Term Certain/Life | | | | | Periodic Retirement Payment  **A TIAA-CREF Distribution Form MUST be completed and accompany this application.** | | | | | **SECTION 2 RETIREE HEALTH INSURANCE CREDIT OPTION (Check One)** | | | | | | | | | | | | | I elect the standard retiree health credit option specific to the retirement payment option selected in section 1.  If married and selected the Single Life, 20 or 10 Year Term Certain, or a Defined Contribution Periodic payment; I elect the following alternate actuarially reduced retiree health credit option.  (Check One):  50% Joint Survivor Life  100% Joint Survivor Life | | | | | | | | | | | | |

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| APPLICATION FOR DISABILITY RETIREMENT  SFN 18000 (Rev. 01-2014) Page 2   |  |  | | --- | --- | | Name (Last, First, Middle) **{stdMbrFullNameLFM}** | NDPERS Member ID **{stdMbrPERSLinkID}** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **PART D SICKNESS OR INJURY DATA** | | | | | | | | | | | | | | | | Date of Sickness or Injury | | Date You First Noticed Symptoms | | | | | | | | Date You First Saw a Physician For This Sickness or Injury | | | | | | Cause of Disability | | | | | | | | | | | | | | | | Name of Treating Physician (If more than one, list on separate sheet of paper.) | | | | | | | | | | | | | | | | Address | | | | | | | | City | | | | | State | Zip Code + 4 | | If Hospitalized For Sickness or Injury, Give Name of Hospital | | | | | | | | | | | Date Admitted | | Date Released | | | Are You Bed Confined?  Yes  No | Are You House Confined?  Yes  No | | | | Have You Ever Had The Same Kind of Sickness or Injury Before?  No  Yes, Specify date and physician’s name and address below. | | | | | | | | | | | Date of Accident? | Time of Accident? | | | | Was Accident Work Related? | | | | | | | Where Did The Accident Occur? | | | | Date You Were First Able To Leave Home For Any Purpose? | | | | | | Date You Were First Able To Do Any Part Of Your Work, Supervisory or Otherwise? | | | | | | | | | | **PART E EDUCATION** | | | | | | | | | | | | | | | | Last Year Completed | | | | Name of School | | | | | | | | | | | | Last Year in School | | | | Degree/Certificate | | | Additional Training | | | | | | | | | Attitude Towards School  Like Dislike | | | | Favorable Courses | | | | | | | | | | | | **PART F MILITARY SERVICE** | | | | | | | | | | | | | | | | Branch | Date  From: To: | | | | | | | | Discharge  Honorable General Other (Specify) | | | | | | | Duties/Responsibilities | | | | | | | | | | | | | | | | Rank | | | Special Training | | | | | | | | | | | | | Service Connected Disabilities | | | | | | | | | | | | | | | |

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| APPLICATION FOR DISABILITY RETIREMENT  SFN 18000 (Rev. 01-2014) Page 3   |  |  | | --- | --- | | Name (Last, First, Middle) **{stdMbrFullNameLFM}** | NDPERS Member ID **{stdMbrPERSLinkID}** |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **PART G WORK HISTORY** (List Most Recent First) | | | | | | | Employer | | Supervisor | | | | | Job Title(s) | | | | | | | Dates:  From: To: | Salary | | | | Duties | | Employer | | | Supervisor | | | | Job Title(s) | | | | | | | Dates:  From: To: | Salary | | | Duties | | | Employer | | | Supervisor | | | | Job Title(s) | | | | | | | Dates:  From: To: | Salary | | | Duties | | | **PART H MEMBER AUTHORIZATION** | | | | | | | **Release of Information:**  To all physicians and other medical professionals, hospitals, and other medical-care, institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrators:  You are authorized to provide MidDakota Clinic and any benefit plan administrators, consumer reporting agencies, attorneys, and independent claim administrators acting on MidDakota Clinic’s behalf with information concerning medical care, advice, treatment, or supplies provided the patient, including information relating to mental illness and any employment related information regarding the patient. This information will be used for the purpose of evaluating and administrating claims for benefits.  In understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. If this authorization is given in connection with a claim for disability or life insurance benefits, I understand that it is valid for the duration of the claim.  I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original. | | | | | | | I elect to receive the retirement benefits and health credit as indicated in PART C. I understand I must submit a photocopy of my birth certificate. (If married, also submit a photocopy of spouse’s birth certificate & marriage certificate)  **I understand that this application for Disability Retirement SFN 18000 must be received by NDPERS at least 30 days before distribution of my first retirement check and within 12 months of termination of NDPERS covered employment.**  Member’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |