



INSTRUCTIONS

PLEASE READ CAREFULLY

Before you complete this application, we strongly recommend that you read the *Ordinary Disability Retirement* brochure.

Filing Information

You are eligible for ordinary disability retirement if you fulfill **all** of the following:

- a) You have at least 10 years of Total Service Credit.
- b) You are in active service with the New York City Department of Education (DOE), the City University of New York (CUNY), or a participating New York City Charter School; however, you have become physically and/or mentally incapable of performing your work duties. (Active service includes being on an approved leave of absence or having transferred-contributor status.)
- c) You file your disability retirement application within 3 months of the last date you were on active payroll; or, if you were on any leave of absence without pay for medical reasons, you file the application within 12 months of the date you receive notice that you have been terminated.
- d) You complete the attached Applicant's Personal Report of Disability and submit the attached "Report of Applicant's Physician" (code DI32) (along with treatment notes) and "Authorization for Release of Health-Related Information" (code DI47), as part of your ordinary disability retirement application, to be filed with TRS.
- e) You are examined by the TRS Medical Board, on whose recommendation the Teachers' Retirement Board approves your ordinary disability retirement.

If you believe that you are eligible for ordinary disability retirement, please complete the application and then, in the presence of a notary public, sign the application where required. You may mail this application to TRS, or someone acting on your behalf may file it at TRS' offices.

Applying for Ordinary Disability Retirement/Effective Retirement Date

Generally, review of your application would take approximately four weeks. TRS will then notify you by mail of the date and time of your interview and examination by the doctors on TRS' Medical Board. You will be notified of the Medical Board's decision by mail. The effective date of your disability retirement would generally be the date you filed your application with TRS, provided you were not on payroll on that date. (If you were on payroll when you filed your application, your retirement date would be the day following your last day on payroll.) If your application is approved, you will have the opportunity to choose a different retirement date; that date must be within 30 days of the date the Medical Board approves your application.

Retirement Payments

Your first disability retirement allowance payment (retroactive to your effective date of retirement) should generally arrive three to five months after the Teachers' Retirement Board approves your application. Your retirement allowance will continue to be paid, according to the payment option you elected, for as long as the Medical Board deems you to be disabled.

TRS issues advance payments approximately one to two months after your effective retirement date to provide you with retirement income as soon as possible. You will continue to receive an advance payment every month until your regular retirement allowance is processed and initiated on payroll. For more information, please see the *Advance Payments* brochure.

Changing Information

You have 30 days after the date that the Medical Board approves your retirement to modify any of the information you provided on your application (excluding any medical reports) by changing the original document at TRS or by filing a new application. Please note that the Applicant's Personal Report of Disability and the "Report of Applicant's Physician" may not be amended after they are filed.

To make changes to your application, you must visit TRS' Walk-In Center on the 2nd floor of 55 Water Street in lower Manhattan and review your changes with a Member Services Representative. If you cannot visit the Walk-In Center, but wish to make changes to your application, then you must cancel your "Tier VI Ordinary Disability Retirement Application" and submit a new one. You may cancel your application by submitting a "Request for Withdrawal of Form/Application/Online Filing" (code MI5). **TRS must receive this form at least one day before your meeting with the Medical Board, regardless of the date on which you mailed the form or the postmark date on the envelope.**

Cancelling Your Application

If you decide not to retire under ordinary disability retirement, you may cancel your "Tier VI Ordinary Disability Retirement Application" by submitting a "Request for Withdrawal of Form/Application/Online Filing." Please note that you may **NOT** cancel your "Tier VI Ordinary Disability Retirement Application" after the Medical Board approves your disability retirement.

Lump-Sum Disability Benefit

In general, if you have been diagnosed with a terminal illness and have a life expectancy of one year or less, or have been diagnosed with a medical condition of a long, continued, and indefinite duration requiring extraordinary care and treatment (regardless of life expectancy), you may be eligible to receive a lump-sum disability benefit payment. This payment would equal the amount payable (as a death benefit) had you died on your last day of active service. For more information about the lump-sum disability benefit, please refer to the *Lump-Sum Disability Benefit* brochure.

Denial of Your Application

Your ordinary disability retirement application may be denied because the Medical Board does not deem you to be physically or mentally disabled at the time of your examination. In this case, you may request that a Special Medical Committee review the conclusions and recommendations of the Medical Board by filing a "Special Medical Committee Request and Waiver of Rights" (code DI13) with TRS; TRS must receive your form within 30 days of the date you receive the transcript of your exam.

General

- When designating beneficiaries on this form, please provide their Social Security numbers (or alternative taxpayer ID numbers). This information will help TRS process any benefits that later become payable without unnecessary delay.
- Loans may not be taken on or after your retirement date.
- For your convenience, TRS forms and publications are available on our website.

HOW TO COMPLETE THE TIER VI ORDINARY DISABILITY RETIREMENT APPLICATION

In Part A: PERSONAL INFORMATION

All information must be provided.

In Part B: ADDITIONAL MEMBERSHIP INFORMATION

Use this section to indicate any additional membership information (e.g., Multiple Employment Membership status or Chapter 683 earnings).

Multiple Employment Membership (MEM) status is assigned to members of TRS who render employment in both primary and secondary TRS-eligible positions during any school year. Once a member attains MEM status, it will remain in effect until his/her retirement or termination of TRS membership. This applies if you are in active service and you held any secondary positions on or after January 1, 1995. (Active service includes being on an approved leave of absence or having transferred-contributor status.) For more information about Multiple Employment, please see the *Multiple Employment Membership Status* brochure.

Chapter 683 earnings apply if you were employed in a special education program, in accordance with Chapter 683 of the Retirement and Social Security Law (RSSL), during the summer preceding your retirement. Please note that confirmation of your Chapter 683 earnings is not available at the time of retirement. TRS will calculate your retirement allowance to include these earnings when confirmation of your Chapter 683 earnings becomes available.

In Part C: TDA ELECTION

If you are a participant in TRS' Tax-Deferred Annuity (TDA) Program, you must make a decision at this time regarding the distribution of your TDA funds. As indicated below, you must file the appropriate form(s), based on your election, in conjunction with filing for retirement.

ACTION	FORM TO FILE
Receive your TDA funds as an annuity separate from your QPP retirement allowance.	"TDA Annuitization Election Form" (code TD6)
Withdraw all of your TDA funds.	"TDA Withdrawal Application" (code TD32)
Defer distribution of your TDA funds to a later date and leave them invested with TRS.	"TDA Deferral Status Election Form (For Retiring Members)" (code TD30)

For more information, please refer to the *TDA Options at Retirement* brochure.

In Part D: RETIREMENT DATE ELECTION

Read the policy regarding how your effective retirement date is determined, then provide your initials in the space provided.

In Part E: PAYMENT OPTION ELECTION AND BENEFICIARY DESIGNATIONS

You must elect **ONLY ONE** payment option in Part E for your retirement allowance and designate beneficiaries if your payment option includes that provision. In all cases, you would receive your retirement allowance for as long as you live. If you want to provide for beneficiaries, you have several choices, each of which would reduce the amount of your monthly retirement allowance. All payments to you and your beneficiaries are monthly and each payment option also enables you to choose a beneficiary for the fractional amount of your retirement allowance. You may add additional beneficiaries by filing the “Retired/Retiring Member’s Additional QPP Beneficiary Form” (code EN22) or online equivalent. For additional information about payment option elections, beneficiaries, and acceptable documents to prove your beneficiaries’ date of birth, please see the *Retirement Payment Options: Tiers III, IV, and VI* brochure. Please note that you may designate a trustee only for lump-sum payments.

Your payment options are categorized as follows:

Maximum Payment Option**Guaranteed Number of Payments Options**

- Option 3 (5-Year Certain)
- Option 4 (10-Year Certain)

Continuing Payment Options

- Option 1
- Option 2

Pop-up Options

- Option 5-1
- Option 5-2

If you elect a Continuing Payment or Pop-up Option:

- These options provide for only one beneficiary. You may change this beneficiary designation up to 30 days after your retirement date.
- Your beneficiary’s age is a factor in computing the amount of your monthly retirement allowance payments; **therefore, you must submit proof of your beneficiary’s date of birth in conjunction with this application.**
- You may not designate a trustee as your beneficiary.

In Part F: DESIGNATION OF BENEFICIARY FOR FRACTIONAL PAYMENT OF RETIREMENT ALLOWANCE AND DEATH BENEFIT #2**Fractional Payment**

In addition to any election you may have made in Part E, you must designate a beneficiary in Part F to receive any fractional payment that may be due for the month in which you die. The fractional payment would be payable provided that you do not die on the last day of the month; the payment would be based on the number of days that you are alive during that month. For example, if you die on the 21st day of a 30-day month, the beneficiary that you designate would receive a payment equaling 21/30 (or 70%) of your monthly retirement allowance.

- The beneficiary you designate to receive your fractional payment need not be the same beneficiary as you designate in Part E.
- You may change your fractional beneficiary designation at any time after you file the “Tier VI Ordinary Disability Retirement Application” by filing a “Designation of QPP Fractional Beneficiary Form” (code EN24) or online equivalent.
- If you have already established a trust, you may designate your trustee as your beneficiary.
- If your beneficiary predeceases you, the fractional payment would be made to your estate.

Death Benefit #2

If you had Death Benefit #2 coverage as an in-service member, you must designate a beneficiary to receive a lump-sum, post-retirement death benefit. This benefit is independent of any death benefit payable under a retirement payment option. The amount of this death benefit would be based on the death benefit in force on your retirement date. If you have already established a trust, you may designate your trustee as your beneficiary. The actual amount payable to your beneficiary would also depend on the amount of time between your retirement date and your death, as shown in the table below.

Year of Death After Retirement Date	Amount of Death Benefit #2
1 st Year	50% of benefit in force on member's retirement date
2 nd Year	25% of benefit in force on member's retirement date
3 rd Year or later	10% of any benefit in force at age 60 (or 10% of the benefit in force on member's retirement date, if retirement occurred before age 60.)

Please note the following:

- The beneficiary you designate to receive your Death Benefit #2 payment need not be the same beneficiary as you designate in Part E.
- If you do not designate a new Death Benefit #2 beneficiary on this application, the most recent QPP beneficiary designation on file would remain in effect.
- If your beneficiary predeceases you, the death benefit payment will be made to your estate.
- You may designate additional beneficiaries by filing a "Retired/Retiring Member's Additional QPP Beneficiary Form" in conjunction with the "Tier VI Ordinary Disability Retirement Application."
- You may change your death benefit beneficiary designation at any time after you file the "Tier VI Ordinary Disability Retirement Application" by filing a "Change of Beneficiary Form for the Post-Retirement Death Benefit under Death Benefit #2" (code EN34) or online equivalent.

In Part G: AFFIRMATION OF UNDERSTANDING

You must sign and date the statement in the presence of a notary public, who must then complete Part H.

In Part H: NOTARIZATION

You must have this form notarized. The date in this notary section must be the same date that you enter in Part G.



ATTACHED FORMS

**APPLICANT'S PERSONAL REPORT OF DISABILITY
"AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION"**

Please complete the Personal Report of Disability and the "Authorization for Release of Health-Related Information," sign and date them, and return them with your "Tier VI Ordinary Disability Retirement Application."

"REPORT OF APPLICANT'S PHYSICIAN"

Please have this form completed, signed, and returned to TRS by your physician.





Please print in black or blue ink, and initial any changes that you make on this application. For each selection that you make throughout this application, you must write your initials in the space provided and check the corresponding box.

PART A: PERSONAL INFORMATION All information must be provided.

First Name	MI	Last Name	Social Security Number (last 4 digits only)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="text"/> <input checked="" type="text"/> <input checked="" type="text"/> - <input checked="" type="text"/> <input checked="" type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Permanent Home Address	Apt. No.		TRS Membership Number
<input type="text"/>	<input type="text"/>		<input type="text"/>
City	State	Zip Code	Primary Phone Number (Check one: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile)
<input type="text"/>	<input type="text"/>	<input type="text"/>	(<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Email Address			Alternate Phone Number (Check one: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile)
<input type="text"/>			(<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of Birth (MM/DD/YYYY):			
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

Check here if you entered new contact information above. TRS will then update our records based on what you entered.

Please keep your contact information up to date. You can visit our website to update your contact information anytime, or file a "Member's Change of Address Form" (code DM13) with TRS.

PART B: ADDITIONAL MEMBERSHIP INFORMATION

Please indicate if the following apply to you:

- Multiple Employment Membership
This applies if you are in active service and you held any secondary position on or after January 1, 1995. Active service includes being on an approved leave of absence or having transferred-contributor status.
- Chapter 683 Earnings
This applies if, during the summer preceding your retirement, you were teaching in a special education program that employs teachers in year-round positions.

PART C: TDA ELECTION

If you are a participant in TRS' TDA Program, please indicate your election for any TDA funds. If you are not a TDA participant, do not complete Part C.

- Receive my TDA funds as an annuity separate from my QPP retirement allowance.
- Withdraw all of my TDA funds.
- Defer distribution of my TDA funds to a later date and leave them invested with TRS.



PART D: RETIREMENT DATE ELECTION

The effective date of your disability retirement would generally be the date you filed your application with TRS, provided you were not on payroll on that date. (If you were on payroll when you filed your application, your retirement date would be the day following your last day on payroll.) If your application is approved, you will have the opportunity to choose a different retirement date; that date must be within 30 days of the date the Medical Board approves your application.

Please read the following statement, check the box, and provide your initials in the space provided.

I have read and understand the above information about how my effective date of retirement will be determined. I understand that I cannot be on payroll as of my retirement date.

PART E: PAYMENT OPTION ELECTION AND BENEFICIARY DESIGNATIONS


Please elect **ONLY ONE** of the payment options listed in Part E. Choose and complete any additional elections under your payment option. If you elect an option that provides a death benefit, you **must** designate a beneficiary. **In addition, all options require a beneficiary for your fractional payment.** If you have already established a trust, you may designate your trustee as your beneficiary for lump-sum payments only.

If you need to designate additional beneficiaries (primary, contingent, or fractional), please file a “Retired/Retiring Member’s Additional QPP Beneficiary Form” (code EN22) or online equivalent.

For more information about the percentage of your retirement allowance that you can leave your beneficiaries, please see the *Retirement Payment Options: Tiers III, IV, and VI* brochure.

MAXIMUM PAYMENT OPTION

Maximum Payment Option Highest monthly retirement allowance, but does not provide a death benefit.

THEN  Go to **Part F** to designate a beneficiary for your fractional payment and for Death Benefit #2.

PART E (Continued)

GUARANTEED NUMBER OF PAYMENTS OPTIONS

Option 3 (5-year certain)

Payment to Beneficiaries

Receives payments only if 60 payments have not been made before your death.

OR

Option 4 (10-year certain)

Receives payments only if 120 payments have not been made before your death.

THEN → Designate your primary and contingent beneficiary below; then go to **Part F** to designate a beneficiary for a fractional payment and for Death Benefit #2.

DESIGNATION OF PRIMARY BENEFICIARY

Beneficiary Name:	Percent (if applicable) ____%	Check One:	Date of Birth: <small>(mm/dd/yyyy)</small>
Street:		Male <input type="checkbox"/>	Relationship:
City, State, Zip:		Female <input type="checkbox"/>	Beneficiary Soc. Sec. No.:
Beneficiary Name:	Percent (if applicable) ____%	Check One:	Date of Birth: <small>(mm/dd/yyyy)</small>
Street:		Male <input type="checkbox"/>	Relationship:
City, State, Zip:		Female <input type="checkbox"/>	Beneficiary Soc. Sec. No.:
Beneficiary Name:	Percent (if applicable) ____%	Check One:	Date of Birth: <small>(mm/dd/yyyy)</small>
Street:		Male <input type="checkbox"/>	Relationship:
City, State, Zip:		Female <input type="checkbox"/>	Beneficiary Soc. Sec. No.:

DESIGNATION OF CONTINGENT BENEFICIARY

Beneficiary Name:	Percent (if applicable) ____%	Check One:	Date of Birth: <small>(mm/dd/yyyy)</small>
Street:		Male <input type="checkbox"/>	Relationship:
City, State, Zip:		Female <input type="checkbox"/>	Beneficiary Soc. Sec. No.:
Beneficiary Name:	Percent (if applicable) ____%	Check One:	Date of Birth: <small>(mm/dd/yyyy)</small>
Street:		Male <input type="checkbox"/>	Relationship:
City, State, Zip:		Female <input type="checkbox"/>	Beneficiary Soc. Sec. No.:

PART E (Continued)

CONTINUING PAYMENT OPTIONS

Option 1

Payment to Beneficiary

Lifetime payments equal to 100% of your reduced monthly retirement allowance.

OR

Option 2

Lifetime payments equal to your choice of 75%, 50%, or 25% of your monthly retirement allowance.

Choose one of the following

75%

50%

25%

OR

Option 5-1 (“Pop-up” option)*

Lifetime payments equal to 100% of your reduced monthly retirement payments.

OR

Option 5-2 (“Pop-up” option)*

Lifetime payments equal to 50% of your reduced monthly retirement payments.

**If beneficiary predeceases you, your payments increase to the maximum.*

THEN 

Designate a beneficiary below; then go to **Part F** to designate a beneficiary for a fractional payment and for Death Benefit #2.

DESIGNATION OF BENEFICIARY

Beneficiary Name:	Check One: Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth: <small>(mm/dd/yyyy)</small>
Street:		Relationship:
City, State, Zip:	Beneficiary Soc. Sec. No.:	

PART F: DESIGNATION OF BENEFICIARIES FOR FRACTIONAL PAYMENT OF RETIREMENT ALLOWANCE AND DEATH BENEFIT #2 (All Payment Options)

Regardless of your election in Part E, you must designate a beneficiary to receive the fractional portion of your retirement allowance for the month in which you die, and you must also designate a beneficiary for Death Benefit #2.

DESIGNATION OF BENEFICIARY FOR FRACTIONAL PAYMENT

Beneficiary Name:	Percent (if applicable) ____%	<i>Check One:</i> Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth: <small>(mm/dd/yyyy)</small>
Street:			Relationship:
City, State, Zip:			Beneficiary Soc. Sec. No.:
Beneficiary Name:	Percent (if applicable) ____%	<i>Check One:</i> Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth: <small>(mm/dd/yyyy)</small>
Street:			Relationship:
City, State, Zip:			Beneficiary Soc. Sec. No.:
Beneficiary Name:	Percent (if applicable) ____%	<i>Check One:</i> Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth: <small>(mm/dd/yyyy)</small>
Street:			Relationship:
City, State, Zip:			Beneficiary Soc. Sec. No.:

DESIGNATION OF BENEFICIARY FOR DEATH BENEFIT #2

Beneficiary Name:	Percent (if applicable) ____%	<i>Check One:</i> Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth: <small>(mm/dd/yyyy)</small>
Street:			Relationship:
City, State, Zip:			Beneficiary Soc. Sec. No.:
Beneficiary Name:	Percent (if applicable) ____%	<i>Check One:</i> Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth: <small>(mm/dd/yyyy)</small>
Street:			Relationship:
City, State, Zip:			Beneficiary Soc. Sec. No.:
Beneficiary Name:	Percent (if applicable) ____%	<i>Check One:</i> Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth: <small>(mm/dd/yyyy)</small>
Street:			Relationship:
City, State, Zip:			Beneficiary Soc. Sec. No.:

PART G: AFFIRMATION OF UNDERSTANDING

Please read the following statement and sign and date below in the presence of a notary.

I affirm that, to the best of my knowledge, all information I have provided above is true and correct. I understand that the filing of this application is irrevocable and cannot be withdrawn as of my retirement date. I also affirm my understanding of the following:

CHANGES AFTER FILING: I understand that any changes I wish to make to this form must be made no later than one day prior to my retirement date, with the exception of the payment options and beneficiaries that I elected in Part E, which may be changed within 30 days after my retirement date.

VERIFICATION OF SERVICE CREDIT: I understand that TRS will verify all service credit in my account as part of my benefit calculation. I also understand that, if TRS determines that I do not have sufficient service credit to retire, TRS may cancel my retirement application.

TERMS OF PAYMENT: If TRS determines that my retirement benefits from TRS are overstated, I am required to repay (or my beneficiaries may be required to repay) the resulting deficit amount in full, in accordance with TRS' applicable rules.

If my retirement allowance payments are transmitted electronically to my financial institution, I authorize and direct my financial institution to immediately refund any overpayments to TRS, including all payments made by TRS on or after the date of my death, and to charge the same to my bank account. TRS' certification of overpayment shall be sufficient evidence of an overpayment.

If the funds remaining are not sufficient to permit my financial institution to fully refund overpayments by TRS, I authorize and direct my financial institution to provide to TRS all information related to the designated account, including withdrawals after the first of the month in which my death occurs, the names and addresses of all joint account holders and any individuals authorized to withdraw funds from the designated account, and any changes of address within one year prior to the date of my death.

MEMBER'S SIGNATURE _____ DATE (MM/DD/YYYY) _____

PART H: NOTARIZATION

TO BE COMPLETED BY A NOTARY (NOTE: Attestation made outside the U.S. must be executed before an American consul.)

State of _____)
) s.s.:
County of _____)

On the _____ day of _____, _____, before me personally appeared the person known to me to be _____, the individual who executed the foregoing instrument and acknowledged to me that (s)he executed the same.

Signature: _____

Official Title: _____ Expiration Date of Commission: _____



**APPLICANT'S PERSONAL
REPORT OF DISABILITY**



TEACHERS' RETIREMENT SYSTEM
OF THE CITY OF NEW YORK (TRS)
55 Water Street, New York, NY 10041
www.trsnyc.org • 1 (888) 8-NYC-TRS

Please Print

Applicant's Name

TRS Membership Number

Address

Primary Phone Number (Check one: Home Work Mobile)

() -

City

State

Zip Code

Alternate Phone Number (Check one: Home Work Mobile)

() -

**TO: TRS Medical Board
Teachers' Retirement System
of the City of New York
55 Water Street, New York, NY 10041**

I believe I am incapacitated and unable to remain employed in my present position because _____

My physician, Dr. _____

(Give name in full.)

of _____, *advises me that*

(Give address.)

SIGNATURE _____ DATE (MM/DD/YYYY) _____

Please use the back of this form to add additional information (if necessary).





REPORT OF APPLICANT'S PHYSICIAN



TEACHERS' RETIREMENT SYSTEM OF THE CITY OF NEW YORK (TRS) 55 Water Street, New York, NY 10041 www.trsnyc.org • 1 (888) 8-NYC-TRS

Please Print

Authorization to be completed and signed by applicant.

Dear Doctor _____:

You are hereby authorized by me to fill out this form and forward it to the Medical Board of the Teachers' Retirement System of the City of New York (TRS), 55 Water Street, New York, NY 10041.

Applicant's Name

TRS Membership Number

Signature: _____ Date (MM/DD/YYYY): _____

To be completed and signed by applicant's physician.

Report of disability in the case of _____

Title: _____ Work location: _____

I certify that the above applicant has been under my professional care since: _____
Month Day Year

The subjective and objective symptoms of which the applicant complains are as follows: _____

Diagnosis: _____

Treatment: _____

Prognosis: _____

In my opinion, and by reason of the above described condition, _____ is physically or mentally incapacitated for the performance of duty; therefore, his/her disability retirement application should be approved.

Signed: _____, M.D. Date (MM/DD/YYYY): _____





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**AUTHORIZATION FOR RELEASE
OF HEALTH-RELATED INFORMATION**



TEACHERS' RETIREMENT SYSTEM
OF THE CITY OF NEW YORK (TRS)
55 Water Street, New York, NY 10041
www.trsnyc.org • 1 (888) 8-NYC-TRS

This form authorizes release of medical information, including HIV-related information, to the Teachers' Retirement System of the City of New York (TRS) pertaining to filing for disability benefits. This authorization complies with the U.S. Department of Health and Human Services Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The information you provide may be protected from disclosure by federal and state privacy laws.

By initialing on page 2 where indicated and signing this form, you agree that medical information and/or HIV-related information may be provided to TRS and the TRS Medical Board and Medical Review Panel for the purpose of determining your eligibility for disability benefits.





**AUTHORIZATION FOR RELEASE
OF HEALTH-RELATED INFORMATION**



TEACHERS' RETIREMENT SYSTEM
OF THE CITY OF NEW YORK (TRS)
55 Water Street, New York, NY 10041
www.trsnyc.org • 1 (888) 8-NYC-TRS

PART A: PERSONAL INFORMATION Please provide the information below.

First Name	MI	Last Name	Social Security Number (last 4 digits only)
<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> - <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Permanent Home Address	Apt. No.	TRS Membership/Retirement Number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
City	State	Zip Code	Primary Phone Number (Check one: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile)
<input type="text"/>	<input type="text"/>	<input type="text"/>	(<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Email Address	Alternate Phone Number (Check one: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Mobile)		
<input type="text"/>	(<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

Check here if you entered new contact information above. TRS will then update our records based on what you entered.
Please keep your contact information up to date. You can visit our website to update your contact information anytime, or file a "Member's Change of Address Form" (code DM13) with TRS.

PART B: Please write your initials in the space provided to confirm your understanding of each statement.

- _____ *I understand that TRS may re-direct the information described on this form on proper request if TRS is not required by applicable law to protect the privacy of this information and such information is no longer protected by federal health information privacy regulations.*

- _____ *I understand that my medical records may contain information related to alcohol or drug abuse, genetic testing, psychiatric care, and/or confidential HIV/AIDS-related information.*

- _____ *I understand that if I am authorizing the use or disclosure of HIV/AIDS-related information, the recipient is prohibited from using or re-disclosing any HIV/AIDS-related information without my authorization unless permitted to do so under federal or state law. I also understand that I have the right to request a list of people who may receive or use my HIV/AIDS-related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at (718) 741-8400 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.*

- _____ *I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above and hereby authorize any hospital, medical group, or other organization to disclose all my medical information to the Teachers' Retirement System of the City of New York (TRS).*

MEMBER'S SIGNATURE _____ DATE (MM/DD/YYYY) _____

