MARYLAND STATE RETIREMENT AGENCY
120 EAST BALTIMORE STREET
BALTIMORE, MD 21202-6700

STATEMENT OF DISABILITY

RETIREMENT USE ONLY

FORM 20 (REV. 7/19)

IMPORTANT: Read the instructions first. Fill in appropriate sections. Print in ink or type.

Name

First Initial Last

Age:_____(Yrs) Gender: _____

Social Security Number:

Home Address:_____
NUMBER AND STREET

_____
NAME OF EMPLOYING AGENCY

_____
CITY AND STATE ZIP CODE

_____
JOB TITLE

Home Phone:_____-_____-_____ Work Phone:_____-_____-_____

Email Address: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby consent to the release of my personnel records from my employer and any records, including medical records, on file with the Workers' Compensation Commission ("WCC"). I also consent to allow the Maryland State Retirement Agency to exchange information with the WCC, other State agencies and units, and the Chesapeake Employers' Insurance Company regarding any past or future disability or workers' compensation awards. This authorization shall remain in effect throughout the disability retirement application process and any appeal. A photocopy of this authorization shall be treated as though it is the original.

Sign & Date _____ _____
APPLICANT'S SIGNATURE **DATE**

This form contains four sections: 1) Applicant/Member, 2) Retirement Coordinator/Employer, 3) Physician, and 4) Important Points to Know.

Your claim is **not submitted** until you properly complete and submit to the Maryland State Retirement Agency Section 1 of this Form 20: *Statement of Disability* and Form 129: *Preliminary Application for Disability Retirement*. Your claim is **not complete** until all of the sections of this Form 20: *Statement of Disability* are properly completed and submitted to the Agency. **Submission of the required forms to the Maryland State Retirement Agency is <u>your responsibility</u>.** Sections 2 and 3 of the Form 20 must be properly completed and submitted within **<u>45 days</u>** of the date your claim is submitted or your disability claim file will be closed and your disability claim will be terminated.

SECTION ONE: APPLICANT/MEMBER

<u>Disability Application:</u>

By signing my name below, I hereby certify that I am mentally or physically incapacitated for the further performance of the normal duties of my position, and that this incapacity is likely to be permanent. I solemnly affirm under the penalties of perjury that all information and responses that I provide in this Statement of Disability are true to the best of my knowledge, information and belief.

Sign & Date _____ _____
APPLICANT'S SIGNATURE **DATE**

All applicants will be evaluated for ordinary disability retirement if the applicant has at least five years of eligibility service.

☐ **Ordinary Disability** I have at least five years of eligibility service.

If your disability is work-related and satisfies the criteria explained below, please select "Accidental Disability" or "Special Disability (State Police)/Accidental Disability (LEOPS)" below. **IMPORTANT:** If you do not apply for accidental or special disability, you may **<u>not</u>** later request accidental/special disability or submit a new claim based on an accident that took place before the date that you submit this form. **CHECK BELOW ONLY IF APPLICABLE**.

☐ **Accidental Disability** I had an accident that occurred in the actual performance of my work duties at a definite time and place without my willful negligence. I am totally and permanently incapacitated for the further performance of duty as the natural and proximate result of the accident.

☐ **Special/Accidental Disability** STATE POLICE / LEOPS ONLY: I am totally and permanently disabled for duty arising out of and in the course of the actual performance of duty without my willful negligence.

THIS SECTION MUST BE COMPLETED IF YOU ARE APPLYING FOR ACCIDENTAL OR SPECIAL DISABILITY

IMPORTANT: List **every** accident that you believe is the cause of your disability. If you are a member of the State Police Retirement System or Law Enforcement Officers' Pension System and your claim is not based on a specific accident, describe how your disability arose out of and in the course of the performance of your job duties. Use additional pages if needed. If you do not identify a work-related accident on this form, you may **not** later request accidental or special disability or submit a new claim based on an accident that took place before the date that you submit this form.

DESCRIBE ACCIDENT: Date: _____ Time:_____ Place:_____

Witness to accident:

Name:_____ Home Phone: ____-____-____ Work Phone: ____-____-____

Address:_____ Work Address: _____

_____ _____

Description of Accident (Attach additional pages if needed.): _____

_____

_____

Have you applied for Workers' Compensation Benefits? ☐ Yes ☐ No

If you apply for and receive any related Workers' Compensation benefits, your accidental or special disability retirement benefit may be reduced. Retirement law requires the Board to reduce your disability retirement allowance by an amount equal to the related Workers' Compensation benefits (less certain statutory exemptions). This may result in a suspension or reduction of your disability retirement allowance for a period of time.

Retirees of a participating governmental unit and retirees of the Employees' Pension/Retirement System who receive disability retirement benefits as an employee of a county board of education or Board of School Commissioners of Baltimore City are not subject to this provision. These retirees may be subject to an offset of their Workers' Compensation benefits in accordance with Md. Code Ann., Labor and Employment Art. §9-610.

If you have applied for Workers' Compensation Benefits, attach copies of all forms submitted to Workers' Compensation Commission and all orders or awards issued by Workers' Compensation Commission for each accident.

ALL APPLICANTS MUST RESPOND TO THE FOLLOWING (Attach additional pages if needed):

1. Describe your disability or medical condition: _____

   _____

   _____

2. Are you receiving Social Security Disability Benefits? ☐ Yes ☐ No ☐ In Progress

3. I agree to appear before the physician(s) designated by the Maryland State Retirement Agency at such time and place as arranged by the Agency if an additional opinion is required by the Medical Board:

Sign _____

APPLICANT'S SIGNATURE

DISABILITY APPLICANTS — EMPLOYMENT

Job where accident or disability occurred:

1. Name of employer: _____
2. Date of hire: _____ Last date of employment (if applicable): _____
3. Job title: _____
4. Description of position held: _____

   _____

5. Describe how your disability affects your job performance: _____

   _____

6. Name and phone number of immediate supervisor or foreman: _____

All other current employment (if different from above):

7. Name of employer: _____
8. Date of hire: _____ Last date of employment (if applicable): _____
9. Job title: _____
10. Description of position held: _____

    _____

The Maryland State Retirement Agency may require additional information upon request. You have a continuing obligation to update and report any changes in employment during the claim process.

By signing my name below, I hereby certify that the information provided is true to the best of my knowledge, information and belief.

Sign & Date _____ _____

APPLICANT'S SIGNATURE DATE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

SOCIAL SECURITY NUMBER ___ – ___ – ____

DATE OF BIRTH ___ – ___ – ____
Month Day Year

NAME
First Initial Last

1. In accordance with Maryland's Health General Article §4-303, I authorize the use or disclosure of the above-named individual's health information as described below.
2. The following individuals or organizations are authorized to make the disclosures:

   Name of employing agency_____

   Name of physician(s) completing Physician's Medical Report _____

   _____
3. The health information may be disclosed to and used by the State Retirement and Pension System of Maryland, State Retirement Agency, 120 E. Baltimore Street, Baltimore, Maryland 21202 for the purpose of the application for disability retirement benefits.
4. The type and amount of information to be used or disclosed is as follows:

   All Medical Records including but not limited to:

   a. Workability evaluations
   b. Examinations done by or at the request of the State Medical Director
   c. Records submitted to the Workers' Compensation Commission
   d. Medical documents, reports, etc. contained in any files maintained by the employing agency.
   e. Treatment notes, test results, x-rays, MRI's or other diagnostic studies, correspondence, and reports from other physicians.
5. I understand that my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services, and/or treatment for alcohol and drug abuse.
6. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
7. This authorization shall expire two years after the date of its execution.

If I have questions about disclosure of my health information, I can contact the State Retirement Agency and speak with a retirement benefits specialist.

Sign & Date

_____ _____
APPLICANT'S SIGNATURE DATE

_____
WITNESS SIGNATURE

SECTION TWO: RETIREMENT COORDINATOR/EMPLOYER

Dear Retirement Coordinator —
A member of your agency is in the process of submitting an application for disability retirement. The following forms must be received in order to open a claim: *Preliminary Application for Disability Retirement* (Form 129) and *Statement of Disability* (Form 20.) In addition, retirement coordinators must submit:

1. Employer's "Report of Accident," if accidental disability is claimed
2. Employee's job description – signed and dated
3. Performance evaluations – last two years
4. Attendance/leave reports – Summary of the last two years (include key explaining any codes)
5. *Application to be Placed on a Qualifying Approved Leave of Absence* (Form 46), if applicable

The retirement coordinator must submit all the applicable documentation listed above to the Maryland State Retirement Agency, 120 East Baltimore Street, Baltimore, MD 21202. This documentation needs to be received by the Retirement Agency within 45 days from the member's submission to you. The employer may also be asked to provide additional information relevant to the determination of the disability claim at a later date.

Name of applicant: _____ Social Security Number: _____

Job title of applicant: _____

Is the employee still employed in this position? ☐ Yes ☐ No

If the employee is still employed in this position, which best describes the employment status of the employee?

☐ Employed - working normal duties and regular schedule
☐ Employed - working normal duties but reduced schedule
☐ Employed - working restricted duties and regular schedule
☐ Employed - working restricted duties and reduced schedule
☐ Employed - not working (on a paid or unpaid leave of absence)
☐ Other - Describe: _____

_____

If the employee is no longer employed in this position, separation was effective on this date: _____, and was due to:

☐ Termination
☐ Resignation
☐ Other – Describe: _____

_____

_____

SECTION TWO: RETIREMENT COORDINATOR/EMPLOYER

Are there any pending disciplinary actions against this employee? ☐ Yes ☐ No If yes, please provided details:

_____

_____

_____

_____

_____

Retirement coordinator: Please date and sign below.

By signing below, I certify that to the best of my knowledge, the answers I have provided above are correct and the information provided (accident report, job description, performance evaluations, and attendance/leave reports) to the Retirement Agency are complete and accurate.

_____ _____
RETIREMENT COORDINATOR NAME (PRINT) **DATE**

_____
RETIREMENT COORDINATOR SIGNATURE

Agency's name and mailing address: _____

_____

Direct phone number: _____ Email address: _____

SECTION THREE: PHYSICIAN

PHYSICIAN'S MEDICAL REPORT

Part One – Completed by Applicant

(Print or type)

Age:_____(Yrs)

Member Name:_____ _____ - _____ - _____ Gender:_____
FIRST INITIAL LAST SOCIAL SECURITY NUMBER

Home Address:_____ _____
NUMBER AND STREET NAME OF EMPLOYING AGENCY

_____ _____
CITY AND STATE ZIP CODE JOB TITLE

Home Phone:_____ - _____ - _____

AUTHORIZATION FOR PHYSICIAN'S MEDICAL REPORT(S)

Dear Doctor:
Please complete the Physician's Medical Report and forward it directly to the Medical Board of the State Retirement Agency. In addition, you are authorized to provide further information regarding my condition to the physician(s) designated by the Retirement System.

Sign & Date _____ _____
APPLICANT'S SIGNATURE **DATE**

Part Two – Physician's Information

PLEASE DO NOT USE ABBREVIATIONS — See page 8 for instructions.

I. HISTORY: (Give subjective complaints, past and present, dates of first and most recent examinations and frequency of visits.)

II. POSITIVE PHYSICAL FINDING: Please show all pertinent findings (with dates)

HEIGHT	WEIGHT	BLOOD PRESSURE

III. POSITIVE LABORATORY FINDINGS AND SPECIAL STUDIES: Give results of all pertinent studies including x-rays, EKG's, etc., with dates. (In the case of EKG's, please attach a copy of the tracing or a detailed description thereof).

IV. DIAGNOSIS: If International Classification of Diseases (ICD) or procedure codes are listed, please include a brief description of the health problem/procedure.

1.

2.

3.

SECTION THREE: PHYSICIAN

Part Two (con't) – Physician's Information

V. TREATMENT AND RESPONSE:

VI. EVALUATION: Please provide your evaluation as to the patient's ability to perform the duties required by his/her employment.

VII. PROGNOSIS:

VIII: Is the applicant permanently and totally incapacitated from a mental or physical condition for the further performance of the normal duties of his or her position?

☐ Yes ☐ No ☐ Undetermined

Why?: _____

_____

REPORTING PHYSICIAN'S NAME AND ADDRESS: **(TYPE OR PRINT)**	Physician's Signature	Specialty	Telephone Number
	Email Address	FAX Number	Date

Part Two – Physician's Information -- Instructions

The patient above has applied for disability retirement with the Maryland State Retirement Agency. Please complete the enclosed Physician's Medical Report and forward it directly to the Medical Board of the Maryland State Retirement Agency (Agency). If this report is not received within 45 days, the applicant's disability claim will be closed.

Once the required documentation has been received, the applicant's claim will be reviewed by a Medical Board. The Medical Board determines the outcome of the applicant's disability claim without the benefit of a personal examination. Therefore, it is critical that you submit adequate documentation to support the claim. The Agency needs sufficient details of any medical problems so that the Medical Board may determine the severity and duration of the medical condition claimed. Listed below are examples of types of reports that may prove beneficial for the Medical Board and, therefore, should be submitted:

- History of visits
- Hospital records (Operative and discharge summaries)
- Physical and diagnostic findings
- Clinical study reports
- Laboratory and special study reports
- Diagnosis and treatment responses
- Physical therapy and response
- Neurological and/or orthopedic consultations
- Updated medical reports from a specialist
- Stress tests, EKG and echocardiogram test results
- Diagnostic studies, including but not limited to x-rays, EEG, myelogram, angiography, CAT scan
- Hypertension cases – six months of blood pressure readings
- Treatment records for the disability claimed, even if they precede the date of the accident

SECTION FOUR: IMPORTANT POINTS TO KNOW

Instructions: Please review the following information when filing for disability retirement. For retirement counseling, call 410-625-5555 or 1-800-492-5909.

☐ Disability Retirement is a two-step process. First, you must file your initial claim package and supply whatever documentation is needed to establish your disability. Once you have been approved for disability, you must take the second step and file your final retirement application. Remember, you are not actually retired until both steps have been completed.

☐ You must complete a *Statement of Disability* (Form 20), a *Preliminary Application for Disability Retirement* (Form 129), an *Application for an Estimate of Disability Retirement Allowances* (Form 21A, Form 22 for State Police, Form 100 for LEOPS), and submit the properly completed forms to the Maryland State Retirement Agency.

☐ Your employer must send your job description (with the signature of the appointing authority or designee and the date), your performance evaluation, and your attendance/leave records.

☐ The Physician's Medical Report must be completed and submitted by your doctor, including medical records needed to support your claim. You are responsible for the payment of any costs in obtaining medical records.

☐ If during the filing process your employer places you on a medical unpaid leave of absence, file an *Application to be Placed on a Qualifying Approved Leave of Absence* (Form 46). Filing this form protects your death benefit while on an unpaid medical leave.

☐ Only a member may file a claim for disability retirement. Generally, membership ends at retirement, at your death, upon withdrawal of contributions, or, for members in systems listed below, as follows:
Teachers' Retirement System ..... Five years after paid employment ends
All Other Systems (Except Judges' or Legislative) ..... Four years after paid employment ends

☐ If your active membership has ended and you have not retired or withdrawn your accumulated contributions, an extended filing period may be available, but you must prove mental or physical incapacitation as the reason for not filing during the membership period as follows:
Teachers' Retirement System ..... One year after membership ends
All Other Systems (Except Judges' or Legislative) ..... Two years after membership ends

☐ Members applying for accidental disability retirement have a five-year accident limitation. An accidental disability application may not be accepted or considered from a member if filed more than five years after the date of the claimed accident. (No accident filing limit applies to members of the Law Enforcement Officers' Pension System, Correctional Officers' Retirement System and the State Police Retirement System.)

☐ An applicant who, at the time of submission of the *Statement of Disability* (Form 20), fails to request accidental disability retirement or fails to identify a work-related accident, may not later request accidental disability retirement or submit a new claim for accidental disability retirement based on a work-related accident that took place before the date the *Statement of Disability* (Form 20) was submitted.

☐ A member or former member who applies for service retirement may apply for disability retirement only if the member or former member submits a properly completed *Statement of Disability* (Form 20) and *Preliminary Application for Disability Retirement* (Form 129) before the effective date of retirement.

☐ If the Board of Trustees approves your claim for disability retirement, you must accept a disability or service retirement within 120 days of the date of notification. If you fail to properly complete and submit the required forms and retire within 120 days of notification, the State Retirement Agency will close your file, your disability claim will be terminated, and you will not be entitled to disability retirement benefits.

☐ IMPORTANT: If you are a state employee, please note that if you are granted a disability retirement and do not retire within 120 days of notification, Maryland regulations provide that you will be considered resigned from your position.

☐ These instructions provide a general summary of the disability claim process. The Maryland State Retirement and Pension System is governed by law, including Division II of the State Personnel and Pensions Article of the Annotated Code of Maryland, and Title 22 of the Code of Maryland Regulations ("COMAR"). Disability benefits are payable in accordance with Title 29, Subtitle 1 of the State Personnel and Pensions Article, and COMAR Title 22, Subtitle 6. If there is a conflict between the law and these instructions, the law prevails.

☐ Go to sra.maryland.gov to view two videos: Overview of Disability Retirement and Filing for Disability Retirement.