PR-13
Rev. 07/06
Disability Determination

Florida Retirement System
Investment Plan Application for Disability Retirement

PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888 FAX: 850-410-2010

Applicant Name: _____ Applicant SSN: _____

Street/PO Box Address: _____ Birth Date: _____

_____

_____ E-Mail: _____

City/State/Zip: _____ Phone: ____ / _____

Present (or last) employer: _____

Title of position held: _____

Last Day Actually Worked: _____ Last Date in Pay Status: _____ Termination Date: _____

Type of Disability Benefit You Are Applying For: ☐ **Regular** ☐ **In-Line-of-Duty**

Describe the illness or injury, which has caused your disability and how it prevents you from performing your usual job duties.

_____

_____

_____

1. Educational Background--Circle the highest grade level you have completed:
Grammar School: 1 2 3 4 5 6 7 8 High School: 9 10 11 12 College: 1 2 3 4 Graduate School: 1 2 3 4 Other:

2. Work History--List your two previous jobs prior to your current employment:

Job: _____ From: ___/___/___ To: ___/___/___
Job: _____ From: ___/___/___ To: ___/___/___

3. If you have any other physical impairments, please describe them and the length of time they have existed:

_____

_____

4. If you have made any Workers' Compensation claims, please list date(s) of accident(s) and employer(s).

Date: _____ Employer: _____
Date: _____ Employer: _____

List the names, addresses, and phone numbers of the physicians currently or most recently treating you:

A. Name of Physician & Address:

_____

_____

_____

_____

Phone: _____

A. Name of Physician & Address:

_____

_____

_____

_____

Phone: _____

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Member Name _____ Member SSN _____

Authorization for Release of Information: I hereby apply for disability retirement benefits. This application is being made because of a disability, which incapacitates me for the performance of any useful work; and I affirm that all information and statements are true and correct to the best of my knowledge.

I hereby authorize any physician, hospital, or clinic to give full and complete information concerning me, or my medical condition, including any prior history to the Division of Retirement, State of Florida, or its authorized representative.

In addition to the above general medical release, I hereby specifically authorize the release of any records, which may exist concerning me, including but not limited to, employment or personnel records with previous employers, including records with a School Board, Community College, or Public School System, or records with other Retirement Systems, the Veteran's Administration, Social Security Administration, Workers' Compensation records, or any other records, which a personal release signed by me may be required. Please cooperate with the bearer of this release. This Authorization for Release of Information is valid throughout the duration of my claim/retirement.

Date: _____ Applicant Signature: _____

Option Selection: You may complete a Form PR-11o, Investment Plan Option Selection for FRS Members, and submit it, along with your application to select an option; or you may wait until an estimate of benefits is provided. A Disability Estimate will be provided if you are approved for disability benefits. However, in the event of your death prior to filing an Option Selection Form, by law, your option selection will default to Option 1, which does not provide a benefit to your beneficiary. If you select an option, you may change the option selection at any time until a benefit payment has been cashed or deposited. You must provide us with your joint annuitant's date of birth to have Options 3 and 4 calculated.

Beneficiary Designation: All previous beneficiary designations are null and void. To designate more than one primary beneficiary, attach a Beneficiary Designation Form, FST-12.

Primary	_____	Primary SSN	_____
Relationship	_____	Primary Birthdate	_____
Contingent	_____	Contingent SSN	_____
Relationship	_____	Contingent Birthdate	____/____/____

I understand I must terminate all employment with FRS employers to receive a retirement benefit under Chapter 121, Florida Statutes. I also understand that I **cannot** change my retirement option once my retirement becomes final. My retirement becomes final when any benefit payment is cashed or deposited. **I understand that in order to receive disability benefits, all monies accumulated in my Investment Plan account will be transferred to the Division of Retirement for deposit in the disability account of the Florida Retirement System Trust Fund.** I understand as a disabled retiree, I cannot work in any capacity and receive a disability benefit. I acknowledge that I have read and understand the Instructions Pages 1 and 2.

Applicant Signature: (sign in the presence of a Notary) _____

Notary: State of Florida, County of _____. The above named person who has sworn to and subscribed before me this _____ day of _____ 20 _____ and is personally known _____ or has produced _____ as identification.

_____ _____
Signature of Notary Public Print, Type or Stamp Commissioned Name of Notary Public