MARYLAND STATE RETIREMENT AGENCY
120 EAST BALTIMORE STREET
BALTIMORE, MD 21202-6700
sra.maryland.gov

EXAMPLE

STATEMENT OF DISABILITY

RETIREMENT USE ONLY

FORM 20 (REV. 2/13)

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

Name: John (FIRST) P (INITIAL) Example (LAST)

000 - 00 - 0000 (SOCIAL SECURITY NUMBER)

Age: 48 (Yrs)

Gender: M

Home Address: 12 Injury Lane (NUMBER AND STREET)

Anytown (CITY AND STATE) Maryland 21000 (ZIP CODE)

Home Phone: 410 - 765 - 0000

State Highway Administration (NAME OF EMPLOYING AGENCY)

Administrator II (JOB TITLE)

Work Phone: 410 - 567 - 1111

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 and Social Security Administration. I also consent to allow the Maryland State Retirement Agency to receive information from the Workers' Compensation Commission regarding any past or future awards and from the Social Security Administration regarding my future earnings. A photocopy of this authorization shall be treated as though it is the original.

Sign & Date — John P Example (APPLICANT'S SIGNATURE) — 2/21/13 (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 your responsibility.** Sections 2 and 3 of the Form 20 must be properly completed and submitted within **45 days** 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

Disability Application:

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 — John P Example (APPLICANT'S SIGNATURE) — 2/21/13 (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 **not** 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: 12-12-12 Time: 2:15 PM Place: Route 100 Hanover

Witness to accident:

Name: Sally Witness Home Phone: 410-567-2222 Work Phone: 410-765-0000

Address: 321 Home Road Anytown, MD 21000 Work Address: 400 High Way Anywhere, MD 21001

Description of Accident: 12-12-12 Sally Witness (co-worker) & I were driving in State car to inspection site. Tractor Trailer swerved into our lane hitting driver's side of state car. I was driving. Impact broke my back, leg & shoulder. Hit head Blind in left eye

Have you applied for Workers' Compensation Benefits? (X) Yes ( ) No

If yes, 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:

1. Describe your disability or medical condition: Broken back, can't walk, accident related Seizures
2. Describe how your disability affects your job performance: Can't walk or drive. Doctor says I will NOT recover or return to work. Lifetime nursing care. Seizures prevent driving
3. Last day you actually worked on the job: 12-12-12 Paid Leave
4. Are you receiving Social Security benefits? ( ) Yes (X) No ( ) In Progress
   (If yes, attach a copy of the approval letter.)
5. Your physician's name: Dr. Maria Trauma
6. Your immediate supervisor or foreman's name: Elizabeth Boss
   Phone: 4107652222 Address: 400 High Way Anywhere MD 21001

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

Sign John Example
APPLICANT'S SIGNATURE

EXAMPLE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

EXAMPLE

SOCIAL SECURITY NUMBER 000-00-0000

DATE OF BIRTH (Month / Day / Year) 01-01-1965

NAME

First: John | Initial: P | Last: EXAMPLE

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 State Highway Administration

   Name of physician(s) completing Physician's Medical Report Maria Trauma MD
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 one year 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

John Example — APPLICANT'S SIGNATURE — 2/21/2013 DATE

Steven Saw — WITNESS SIGNATURE

EXAMPLE

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
6. *Application for an Estimate of Disability Retirement Allowances* (Form 21A, Form 22 for State Police, Form 100 for LEOPS)

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 at a later date.

Name of applicant: John P. Example Social Security Number: 000-00-0000

Job title of applicant: Administrator II

Retirement coordinator: Please date and sign below.

Mary R. Coordinator — RETIREMENT COORDINATOR NAME (PRINT)

2/21/13 — DATE

Mary R Coordinator — RETIREMENT COORDINATOR SIGNATURE

Agency's name and mailing address: State Highway Administration
400 High Way Anywhere MD 21000

Direct phone number: 410 765 3333

E-mail address: Mcoordinator@SHA.Maryland.gov

SECTION THREE: PHYSICIAN

PHYSICIAN'S MEDICAL REPORT

Part One – Completed by Applicant

EXAMPLE

(Print or type)

Member Name: John P Example (FIRST / INITIAL / LAST)

000 - 00 - 0000 (SOCIAL SECURITY NUMBER)

Age: 48 (Yrs)

Gender: M

Home Address: 12 Injury Lane (NUMBER AND STREET)

State Highway Administration (NAME OF EMPLOYING AGENCY)

Anytown MD 21000 (CITY AND STATE / ZIP CODE)

Administrator II (JOB TITLE)

Home Phone: 410 - 765 - 0000

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

J K Example (APPLICANT'S SIGNATURE)

2/21/13 (DATE)

Part Two – Physician's Information

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

EXAMPLE

SECTION THREE: PHYSICIAN

Part Two (cont'd) – Physician's Information

PLEASE DO NOT USE ABBREVIATIONS

I. HISTORY: (Give subjective complaints, past and present, dates of first and most recent examinations and frequency of visits.) 12/12/12 Autoaccident
12/12/12–1/18/13 Shock-trauma
1/18/13–1/23/13 ICU
1/23/13–2/2/13 Monitor
2/2/13 Nursing care – Trauma Home Care
2/23/13 Disability Exam
TBI. Paralysis Blind (L)
Seizures
Spinal Trauma

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

HEIGHT	WEIGHT	BLOOD PRESSURE
6'1	212	115-60

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:
1. Spinal Cord/Bone Trauma (952) Paralysis
2. Traumatic Brain Injury TBI 907.0
Seizures Epilepsy
3. Blind L Retina Detach 780.39

V. TREATMENT AND RESPONSE:

Trauma Care Nursing Care Surgery Bladder Control Med

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

Unable to work 24/7 Care Needed!

VII. PROGNOSIS Poor

Paralysis – Complete No Sensory Motor Function
Chronic Pain Complications

VIII: Is the applicant permanently and totally disabled from performing the duties of his or her position?

Permanently Totally Disabled Of Recovery

REPORTING PHYSICIAN'S NAME AND ADDRESS: **(TYPE OR PRINT)**	Physician's Signature	Specialty Ortho Surgeon Shock Trauma
Maria E. Trauma LLPMD 1 Trauma Lane Emergency, MD 21911	Telephone Number 410 911 0000	Date 2/23/13

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

PRELIMINARY APPLICATION FOR DISABILITY RETIREMENT

EXAMPLE

RETIREMENT USE ONLY

FORM 129 (REV. 2/13)

APPLICANT'S SOCIAL SECURITY NUMBER: 000-00-0000

HOME PHONE NUMBER: 410-765-0000

GENDER (M or F): M

DATE OF BIRTH (Month / Day / Year): 01 / 01 / 1965

APPLICANT'S NAME: First: JOHN | Initial: P | Last: EXAMPLE

HOME ADDRESS (Number and Street): 12 INJURY LANE

City: ANYTOWN | State: MD | Zip Code: 21000-

Purpose. The purpose of filing a *Preliminary Application for Disability Retirement* (Form 129) is to protect the benefit payable to the beneficiary, designated below in Option 2, if I am granted a disability retirement allowance but die during the Applicable Period (as defined below). If I die after the expiration of the Applicable Period, this application shall have no force and effect and no benefits shall be payable under this application. "Applicable Period," for the purposes of this form, means the period that begins on the date that I submit a completed *Preliminary Application for Disability Retirement* (Form 129) to the Maryland State Retirement Agency and that ends on the first to occur of the following: (1) the date the applicant submits a completed *Application for Disability Retirement* (Form 13-23) or (2) the date required for submitting an *Application for Disability Retirement* (Form 13-23) under COMAR 22.06.05.03 - .04.

Application. By filing this *Preliminary Application for Disability Retirement* (Form 129) with the Maryland State Retirement Agency, I hereby apply for and accept a disability retirement allowance. I understand that a disability retirement benefit is payable under this Preliminary Application only if, during the Applicable Period, the Board of Trustees grants me a disability retirement allowance and I die before filing an *Application for Disability Retirement* (Form 13-23).

Effective Date. The effective date of my disability retirement shall be as provided in COMAR 22.06.05.06.

Selection of Allowance. Instead of the basic allowance, I hereby elect to receive a reduced allowance to be paid as one of the following options. **Place an "X" next to the payment Option you choose - (1) or (2)**

☐ **Option 1 - Lump Sum:**
I elect to have the Option 1 allowance under which the present value of my retirement benefit is paid at my death in a lump sum to the most recent designation of beneficiary(ies) on file with the Maryland State Retirement Agency. The beneficiary designation can be changed by completing a *Designation of Beneficiary* (Form 4).

☒ **Option 2 - Survivor Annuity:**
I elect to have the Option 2 allowance under which 100% of the allowance payable to me shall be paid to the beneficiary listed below for his or her lifetime. Only one beneficiary can be designated under Option 2. **You cannot designate a beneficiary under Option 2 who is more than 10 years younger unless the beneficiary is your spouse or disabled child.**

Complete only if you selected Option 2:

Beneficiary's Name: JANE EXAMPLE | Beneficiary's address: 1 SPOUSE Rd. Anytown 21234

Birth Date: 12-25-65 | Gender (circle): M (F) | Relationship (check): Spouse ☒ Disabled child ☐ Other ☐

If selecting Spouse, please indicate state/jurisdiction where marriage license was issued: Anytown MD

Date of marriage: 6-1-88 | I understand my beneficiary is required to provide the agency with proof of birth.

Effect of Pursuing Other Claims. I understand that if I die after having been granted an ordinary disability allowance but while pursuing a claim for an accidental disability allowance, the claim shall terminate and survivor benefits shall be payable for the ordinary disability retirement allowance, according to the optional form of allowance selected under that benefit.

If Power of Attorney signs, copy of Power of Attorney must accompany this application.

Applicant's Signature or Signature of Power of Attorney: John P Example | Date: 2/21/13

This form must be signed and notarized in order to be valid.

State of Maryland County of SOMEWHERE (or City of Baltimore)
On this 21 day of February, 20 13, before me, the undersigned officer, personally appeared John P Example, known to me
NAME OF PERSON WHOSE SIGNATURE IS BEING ACKNOWLEDGED *
(or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledged that (he/she) executed the same for the purposes therein contained. In witness whereof I hereunto set my hand and official seal.

Official Seal must be affixed

Signature of Notary Public: Mary R. Coordinator
Printed Name of Notary Public: Mary R. Coordinator | My Commission Expires: 12/1/2014

* IMPORTANT: If the name of the individual whose signature is being acknowledged is not filled in, this form will be INVALID and have no legal effect.

Retirement Coordinator Signature: Mary R. Coordinator | Date 2/21/2013

Retirement Coordinator Printed Name: Mary R. Coordinator | Agency SHA

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

EXAMPLE

APPLICATION FOR AN ESTIMATE OF DISABILITY RETIREMENT ALLOWANCES

IMPORTANT: To be completed by member: Print in ink or type. If you need assistance in completing this application, telephone a retirement benefits specialist at 410-625-5555 or toll-free 1-800-492-5909.

RETIREMENT USE ONLY

FORM 21A (REV. 3/12)

To be completed by the member*. At actual retirement, if your effective date is other than the first of a month, your monthly retirement benefit will not commence until the first of the month following your selected retirement date. Benefits are paid at the end of each month for the month just ended.

* Application by Surviving Beneficiary: Your surviving beneficiary may be eligible to apply for a benefit if you die within seven days of completing the *Preliminary Application for Disability Retirement* (Form 129) and the Maryland State Retirement Agency receives the form within 30 days of your death. In this situation, your beneficiary should contact the Maryland State Retirement agency for filing instructions.

TYPE OF DISABILITY: (PLEASE CHECK): ( ) **ORDINARY** (X) **ACCIDENTAL**

SOCIAL SECURITY NUMBER: 000-00-0000

EFFECTIVE DATE OF RETIREMENT: ___ - ___ - ____ (MO - DAY - YR)

DAYTIME TELEPHONE NUMBER: 410-765-0000

NAME: JOHN (FIRST) P (INITIAL) EXAMPLE (LAST)

ADDRESS: 12 INJURY LANE (NUMBER AND STREET)

ANYTOWN MARYLAND (CITY AND STATE) 21000 (ZIP CODE)

RETIREMENT ALLOWANCES: If you name a beneficiary, you will receive an estimate for the Basic Allowance and all option allowances (1-6). If no beneficiary is named, you will receive an estimate for the Basic Allowance and Options 1 and 4 only. Remember, once your first retirement check is paid, you many not change your allowance option.

IF OPTION 2, 3, 5 or 6 IS REQUESTED INDICATE:

Relationship (check): Spouse X Disabled child ____ Other ____

Beneficiary's Date of Birth: 12-25-1965 Beneficiary's Gender: F

Beneficiary's Name: JANE EXAMPLE

If selecting Spouse, please indicate state/jurisdiction where marriage license was issued: _____ Date of marriage: _____

If electing Option 2 or 5, you cannot designate a beneficiary who is more than 10 years younger unless the beneficiary is your spouse or disabled child.

BASIC: The Basic Allowance pays you the largest possible amount of money each month until your death. All monthly payments stop at your death. After your death, your beneficiary or estate will receive one payment if your death occurs on the 16th of the month or later.

OPTION 1: Provides a lower monthly benefit than the Basic Allowance, but guarantees monthly payments that equal the total of your retirement benefit's Present Value. The Present Value of your benefit is figured at the time of your retirement. If you die before receiving monthly payments that add up to the Present Value, the remaining payments will be paid in a lump sum to your designated beneficiary or beneficiaries who remain alive.

OPTION 2: Provides a lower monthly benefit than the Basic Allowance, but guarantees that after your death the same monthly benefit will continue to be paid to your surviving beneficiary for his or her lifetime. No further payments will be made after the deaths of you and your beneficiary. If you choose this option, you must send proof of your beneficiary's date of birth with your final retirement application.

OPTION 3: Provides a lower monthly benefit than the Basic Allowance, but guarantees that after your death one half of the monthly benefit paid to you will be paid to your surviving beneficiary for his or her lifetime. No further payments will be made after the deaths of you and your beneficiary. If you choose this option, you must send proof of your beneficiary's date of birth with your final retirement application.

OPTION 4: Provides a lower monthly benefit than the Basic Allowance, but guarantees the return of your accumulated contributions and interest as established when you retire. If you die before you have recovered the full amount of your accumulated contributions and interest, the remainder will be paid in a lump sum to your designated beneficiary or beneficiaries who remain alive.

OPTION 5: Provides a lower monthly benefit than the Basic Allowance, but guarantees that after your death the same monthly benefit paid to you will be paid to your surviving beneficiary for his or her lifetime. It also provides that your monthly benefit will "pop-up" to the Basic Allowance for your lifetime if your beneficiary dies before you. If your original beneficiary dies and you are collecting the Basic Allowance and decide to name a new beneficiary, your benefit will be recalculated under Option 5 based on the new beneficiary designation. If you choose this option, you must send proof of your beneficiary's date of birth with your final retirement application.

OPTION 6: Provides a lower monthly benefit than the Basic Allowance, but guarantees that, after your death, one half of the monthly benefit paid to you will be paid to your surviving beneficiary for his or her lifetime. It also provides that your monthly benefit will "pop-up" to the Basic Allowance for your lifetime if your beneficiary dies before you. If your original beneficiary dies and you are collecting the Basic Allowance and decide to name a new beneficiary, your benefit will be recalculated under Option 6 based on the new beneficiary designation. If you choose this option, you must send proof of your beneficiary's date of birth with your final retirement application.

Do you wish to purchase any previous service for which you are eligible? ( ) YES ( ) NO
If yes, obtain a request to purchase previous service from your retirement coordinator and attach a copy with this application.

John Example
Member's Signature

2/21/2013
Date