MCERS FORM: DIS-2
Adopted: 05/01/99
Revised: 07/24/17

MONROE COUNTY EMPLOYEES RETIREMENT SYSTEM

APPLICATION FOR DISABILITY RETIREMENT

(To be filled out in Ink - Please Print)

MEMBERSHIP NUMBER

Submitted by: __ __ Member ___Department Head

1. Claimant's Name	8. State the nature of your disability. Is your disability total?
2. Residence Address/Telephone/Email	9. What duties can you not perform? Is your disability permanent?
3. Date of Birth _____Month_____Day_____Year	10. Is your disability duty related? Please explain.
4. Department/Division	11. When did you first notice your disability? (Please provide date)
5. Marital Status	12. When did you first consult a physician about your disability?
6. Do you have an EDRO on file	13. Are you receiving worker's compensation benefits?
7. Date you last attended to your duties.	14. If your disability is the result of an accident, give names and addresses of witnesses.

15. Give full explanation of the nature and cause of your disability.

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16. Name and addresses of physicians you have consulted in connection with your disability.

NAME ADDRESS DATES OF ATTENDANCE

_____

_____

_____

17. Name and addresses of physicians you have consulted with regarding any medical condition within the last 10 years.

NAME ADDRESS DATE OF ATTENDANCE

_____

18. The Member's designated physician to serve on the Medical Committee is:

NAME ADDRESS PHONE

_____

The undersigned member hereby makes claim to the Monroe County Employees Retirement System for disability benefits and authorizes the above named physicians who have attended the member to report directly to the Medical Advisor for the Retirement System regarding the member's physical conditions. The undersigned member agrees that the furnishing of this form or other forms supplemental hereto by the Retirement System is not to be considered nor constitute an admission of liability by the Retirement System

Dated at _____this _____day of _____20_____.

_____ _____

_____ _____

Signature of Department Head **Signature of Member**