



APPLICATION FOR DISABILITY BENEFITS DS0260 (REV. 10/08)

Coverage A Coverage B

- I am applying for a disability benefit.
- I am re-applying for a disability benefit.
- I am/have been receiving limited-term disability benefits.

Name: (Last)	(First)	(M/I)	Social Security Number - -
(Street Address)	(Apt. #)		Birthdate (Mo./Day/Yr.) / /
(City)	(State)	(Zip Code)	Home Telephone ()

The dates of your last day of work and compensation are necessary to establish a benefit effective date. If you are currently working, a projected last day of work is required. If your application for disability is approved, benefits will not be payable until the day after your last day of compensation.

Currently Working? <input type="checkbox"/> No <input type="checkbox"/> Yes	Last Day of Work: (Mo./Day/Yr.)	Last Day of Compensation: (Mo./Day/Yr.)	Disability Effective Date: (Mo./Day/Yr.)
Is your disability due to an "Unlawful Act" of bodily injury that occurred on the job? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, explain on page 5 and attach supporting documentation – Police Report and/or official Employer Incident Report		County:	District of Employment:
<p style="text-align: center;">Final Compensation</p> <p>If your highest compensation earnable was any year prior to your last 3 consecutive years of service, enter the beginning date of that year. One-year final compensation is available for classroom teachers provided it has been included in a written collective bargaining agreement.</p>			Final Compensation begin date: (Mo./Day/Yr.)

OTHER RETIREMENT SYSTEMS

If you are a member of any of the following California Public Retirement Systems, please place an "X" in the appropriate box(es).

Check all that apply: <input type="checkbox"/> California Public Employees Retirement System <input type="checkbox"/> San Francisco Community College Retirement System <input type="checkbox"/> Legislators' Retirement System <input type="checkbox"/> University of California Retirement System <input type="checkbox"/> 1937 Act County Retirement System (See list) →	Retirement Date with that System: (Mo./Day/Yr.) County Name: List of 1937 Act County Retirement Systems: Alameda, Contra Costa, Fresno, Imperial, Kern, Los Angeles Marin, Mendocino, Merced, Orange, Sacramento, San Bernardino, San Diego, San Joaquin, San Mateo, Santa Barbara, Sonoma, Stanislaus, Tulare, Ventura
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SUBROGATION INFORMATION NOTICE

If you or any of your family pursue a CIVIL CLAIM against any person or entity as a result of your disability, CalSTRS MUST BE NOTIFIED. This is true even if the claim has not yet been filed in court. CalSTRS has the right to participate in any such claim by filing its own action against the responsible party, intervening in the filed claim, or filing a lien against any judgement which may be recovered. IF YOU OR A FAMILY MEMBER(S) SETTLE SUCH A CLAIM WITHOUT NOTIFYING CalSTRS, CalSTRS MAY FILE A LAWSUIT AGAINST EITHER YOU OR ANY OF YOU FOR RECOVERY OF CalSTRS SUBROGATION RIGHTS.

As of the signature date, have you or any member of your family filed or plan to file a civil suit claiming your disabling condition was caused by a third party's negligence? (Please check one box after reading notice above.)
 No Yes - Complete the following information:

Defendant's Name(s):	Defendant's Insurance Company:
Defendant's Attorney(s) Name/Telephone:	Plaintiff's Attorney(s) Name/Telephone:

DEPENDENT INFORMATION

Disability Allowance (Coverage A)	In accordance with Ed Code Section 22123, list all offspring including any step-child(ren) who are under 22 years of age and who are unmarried or not in a registered domestic partnership and who are financially dependent upon the member on the effective date of the member's disability allowance. "Financially Dependent" as defined under this section, which states in part, "that at least one-half of the child's support was being provided by the member." A copy of the original birth certificate is required for each child listed. If a child does not have a Social Security Number, one must be obtained prior to the payment of any benefits for that child.
Disability Retirement (Coverage B)	In accordance with Ed Code Section 22123.5, list all offspring or step-child(ren) who are under 21 years of age and who are financially dependent upon the member on the effective date of the member's disability retirement. "Financially Dependent" as defined under this section, which states in part, "that at least one-half of the child's support was being provided by the member". A copy of the original birth certificate is required for each child listed. If a child does not have a Social Security Number, one must be obtained prior to the payment of any benefits for that child.
Social Security Number	Name: Last First M/I Birth Date: (Mo./ Day /Yr.)
- -	/ /
- -	/ /
- -	/ /
- -	/ /

QUALIFICATIONS

- Medically determinable physical or mental impairment that is permanent or expected to last continuously for at least 12 months.
- Impairment prevents the member from performing his/her normal duty assignment(s) for employer, normal duties with reasonable accommodation, or the duties of a position at a comparable salary level for which the member can become qualified within a reasonable period of time by education, training, or experience.
- Not applying because of a physical or mental condition that existed at the time of most recent membership in the System and which remains substantially unchanged (a pre-existing condition).
- Five or more years of credited California service, at least four years of which are credited for actual service performed in a position requiring membership in the System (this requirement may be amended to require one year of service credit for members who are victims of an unlawful act of bodily injury while in the performance of duty).
- For Coverage A only: Applicants must be less than 60 years of age to file an application.

REQUIREMENTS

Information requested on this form is mandatory and necessary for the determination of your eligibility for benefits. The California Education Code provides the authority to obtain the requested information. Any information not provided may result in cancellation of your application. You have the right to review the file maintained on this case by CalSTRS upon request and submission of the proper identification. For further information, you may contact our Call Center at the address or telephone number at the bottom of page 1 of this application.

To process your application, sign in the box at the bottom of this page authorizing CalSTRS to obtain additional information from your doctors, hospitals, or information regarding earnings or Workers' Compensation.

AUTHORIZATIONS

I hereby authorize and direct any and all organizations, agencies, and individuals from whom the California State Teachers' Retirement System or its representatives requires' information to determine my disability status, to disclose all requested information, which they may possess. Such information may include, but is not limited to, medical or hospital reports, any benefit or rehabilitation information, tax returns, and legal documents and decisions. The sources may be, but are not limited to, (1) physicians; (2) hospitals; (3) State agencies, such as the California Franchise Tax Board, and the Department of Industrial Relations; (4) Federal agencies such as the United States Internal Revenue Service, Social Security Administration and the Veterans Administration; (5) any retirement or pension plan; (6) insurance companies, particularly the workers' compensation insurance carriers; (7) rehabilitation firms; (8) psychiatric, psychological or counselor practitioners; and (9) universities and colleges.

The information requested will be used to verify my present and past medical, legal and financial status for the purposes of determining eligibility for and/or continuing qualification for receiving a disability benefit. Rehabilitation/vocational information requested will be used for determining employment or rehabilitation potential and/or to assist in vocational rehabilitation planning.

In submitting this application, I agree, pursuant to California Education Code Section 22450, to submit financial information, statements, and/or certified copies of state and federal income tax returns, upon request by the California State Teachers' Retirement System (CalSTRS), for either establishing eligibility for a disability benefit or continuing qualification to receive a disability benefit. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization remains valid during the entire period my application is being considered and/or I am receiving a Disability Benefit from CalSTRS.

Applicant's Signature 	DATE: (Mo./Day/Yr.)
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CURRENT MEDICAL STATUS

Disabled Since: (Mo./Day/Yr.)	Will be unable to work because of this disability for: <input type="checkbox"/> Less than 12 months <input type="checkbox"/> 12 or more months		
Last Day of Compensation: (includes pay received for sick leave/sub-differential) (Mo./Day/Yr.)	Number of days missed due to this impairment: Current Yr.: Previous Yr.:		
Present Physician's Name:	Specialty: (If any)		
Address:	Patient of this Physician since: (Mo./Day/Yr.)		
	Frequency of visits:		
	Telephone: () -		
Please provide a list of physician(s) that examined or treated for this impairment. Identify all medical information that you feel may have a bearing on your application. (Use a separate sheet if needed)			
Physician(s), Mailing Address			
Diagnosis Date (Mo./Day/Yr.)			
Treatment			
Please provide list of hospital(s) and hospital physician(s) where you were examined or treated for this impairment. Identify all medical information that you feel may have a bearing on your application. (Use a separate sheet if needed)			
Hospital(s), Mailing Address, (Include patient ID #)			
Hospital Physician(s), Mailing Address			
Dates Hospitalized	From: (Mo./Day/Yr.)	From: (Mo./Day/Yr.)	From: (Mo./Day/Yr.)
	To: (Mo./Day/Yr.)	To: (Mo./Day/Yr.)	To: (Mo./Day/Yr.)

EMPLOYMENT INFORMATION

SCHOOL NAME:		SUPERVISOR'S NAME/TITLE:	
ADDRESS:		SCHOOL TELEPHONE NUMBER	() -
CITY, STATE:		SUBJECTS TAUGHT:	
ZIP CODE:		POSITION TITLE:	
GRADE LEVEL:		HOW LONG HELD:	

Has your normal duty assignment been eliminated or modified to compensate for the limitation or impairment that occurred since your initial employment in your school district? No Yes - If Yes, complete the following:

DUTY ASSIGNMENT	HOW ELIMINATED OR MODIFIED	DATE	REASON FOR ACTION

DEGREES HELD OR IN PROGRESS

DEGREE	DATE	FIELD	DEGREE	DATE	FIELD

PROFESSIONAL CREDENTIALS AND VOCATIONAL CERTIFICATES OR LICENSES

(Education, law, medicine, nursing, accounting, craft union, associations, etc.)

CREDENTIAL/CERTIFICATE	ISSUED BY	ISSUE DATE	EXPIRATION DATE

Have you had experience in the education field other than your present position? If so, please describe and provide the dates:

Have you had work experience/training in a field other than education? If so, please describe and provide the dates:

Have you discussed with your school district, the possibility of a reasonable accommodation that would allow you to continue working?

- No - You may be required to request a reasonable accommodation to prevent the cancellation of your disability application.
 Yes - With whom and what was the outcome?: _____ (Please attach a copy of the final communication)

Have you had any contact with the California Department of Rehabilitation or with a rehabilitation counselor from Workers' Compensation?

- No
 Yes - With whom and what was the outcome? _____

DISABILITY ALLOWANCE ONLY Coverage A:

Are you now receiving or plan to apply for benefits from Workers' Compensation or an insurance carrier where your employer pays your premium?

- No
 Yes - Please provide insurance carrier, claim # : _____

DISABILITY RETIREMENT ONLY Coverage B:

Are you now receiving or plan to apply for benefits from Workers' Compensation?

- No
 Yes - Please provide insurance carrier, claim # : _____

STATEMENT OF DISABILITY


Please state your disability and how it prevents you from working in your normal or current duty assignment. Include job duties you can no longer perform at a satisfactory level because of your disability. (Use a separate sheet if needed.)

REQUIRED SIGNATURES

Sign in the appropriate signature box(es).

DISABILITY ALLOWANCE (COVERAGE A ONLY):

I have read the attached instructions and understand that submitting an incomplete application may delay payment of benefits. I certify under penalty of perjury under the laws of the State of California that the information submitted here is full, complete and true to the best of my knowledge, and that no material facts have been omitted. I understand that perjury is punishable by imprisonment in the State Prison for up to four (4) years, Penal code section 126.

MEMBER SIGNATURE  _____ DATE _____

DISABILITY RETIREMENT (COVERAGE B ONLY): Check one of the options below.

- I am married or registered as a domestic partner and both our signatures are below.
OR
 I am married or registered as a domestic partner and my spouse or registered domestic partner did not sign below. I have completed the Justification for Non-Signature of Spouse or Registered Domestic Partner section and my signature is below.
OR
 I am not married or registered as a domestic partner. I have never been married or in a domestic partnership, or I am widowed or my domestic partner has died. My signature is below.
OR
 I am divorced or have terminated my registered domestic partnership. Date of divorce or termination: _____.
My signature is below. (mm/dd/yyyy)

I certify under penalty of perjury under the laws of the state of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

MEMBER SIGNATURE  _____ DATE _____


SPOUSE/PARTNER SIGNATURE  _____ DATE _____

JUSTIFICATION FOR NON-SIGNATURE OF SPOUSE/REGISTERED DOMESTIC PARTNER (COVERAGE B ONLY)

As required by Education Code section 22453, any request related to the selection of benefits by a member in which spousal or registered domestic partner interest may be present, such as the forms listed below, requires the signature of the spouse or registered domestic partner unless one of the following conditions exists. If you are married or registered as a domestic partner and your spouse or partner does not sign this application, you must check the appropriate box indicating the reason your spouse or partner did not sign.

- I do not know and have taken all reasonable steps to determine the whereabouts of my spouse or partner.
- My spouse or partner is incapable of executing the acknowledgment because of an incapacitating mental or physical condition.
- My current spouse has no identifiable community property interest in the benefits.
- My spouse or registered domestic partner and I have executed a settlement agreement that makes the community property law inapplicable to the marriage or registered domestic partnership.
- My spouse or partner has refused to sign the acknowledgment. Court action will be or has been initiated to enforce or waive the signature requirement for my spouse or partner. (CalSTRS must have a certified copy of the court order before any benefits can be paid. Please submit a certified copy of the court order when you receive it.) Education Code section 22454

I hereby certify under penalty of perjury under the laws of the state of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

MEMBER SIGNATURE  _____ DATE _____