Form: P-52 (Application)
(Revised 8-28-95)

HIGHWAY AND TRANSPORTATION EMPLOYEES' AND HIGHWAY PATROL RETIREMENT SYSTEM

APPLICATION FOR DISABILITY BENEFITS

I hereby make application for disability benefits under the provisions of the Highway and Transportation Employees' and Highway Patrol Retirement System.

Name_______________________________________ Social Security No.____________________

Address____

Read the provisions on pages 2, 3, and 4 of this form, then select one of the following:

( ) **Normal Disability Benefits -** My physical condition prohibits me from performing the duties of my present position or any other position in the department for which I am suited.

( ) **Work-Related Disability Benefits -** My physical condition prohibits me from performing the essential duties of my normal occupation which is the job or work I performed on the date preceding the date of disability. This disability is a result of an injury incurred during the performance of my duties.

( ) **Long-Term Disability Benefits -** My physical condition prohibits me from performing the essential duties of my normal occupation which is the job or work I performed on the date preceding the date of disability. My disability has been diagnosed as being of such a nature as to exist for more than one year.

I understand that upon the effective date of benefits for normal disability and after monthly benefits have been effective for twelve (12) full months for work-related and long-term disability, I will continue to be eligible for benefits provided I have not regained my earning capacity and I am unable to perform the essential duties of any occupation for which I may reasonably become qualified for by training, education, or experience, including a rehabilitative program, to the extent that I can earn at least fifty percent (50%) of my current annualized rate of pay for the position I held on the date preceding the date of disability.

Are you now totally and continuously unable to engage in any gainful occupation for which you are reasonably qualified by education, training, or experience? Explain fully:______________________________

____

____

Name of all physicians who have treated you since the beginning of this disability.

Name	Dates of Treatment From	To

( )Yes ( ) No Is this disability work-related?
( )Yes ( ) No If yes, have you applied or do you intend to apply for Workers' Compensation?
( )Yes ( ) No Are you receiving or entitled to receive payments from Workers' Compensation? If yes,
( ) Lump Sum Amount $__________________
( ) Weekly Payments Amount $__________________for__________weeks

I agree to notify the Highway and Transportation Employees' and Highway Patrol Retirement System or the Division, District, or Troop where I was working immediately prior to my disability should I recover sufficiently to perform the duties of my position or accept employment elsewhere in order that a determination can be made as to whether or not benefits should be terminated.

2

As a member requesting normal or work-related disability benefits, I am vitally interested in the retirement system and hereby make myself available for such advice and discussion as is necessary to assure the continuation of a sound retirement program for such employees.

I represent that I have provided complete answers to the above questions and that said answers are true and correct to the best of my knowledge.

I herewith authorize any doctor or medical institution, my present or former employer(s), insurance carrier(s), including Workers' Compensation carrier(s), having information concerning me, to release said information to the Highway and Transportation Employees' and Highway Patrol Retirement System and or its designated representative to be used for claims evaluation and auditing purposes only.

Date of Application__________________________Signature____________________________________

THE FOLLOWING INFORMATION MUST BE SUBMITTED WITH YOUR APPLICATION IN ORDER TO PROCESS YOUR CLAIM FOR DISABILITY BENEFITS.

1. Employer's Statement of Disability
2. Attending Physician's Statement
3. Copy of claim filed for Social Security Disability Benefits (work-related and long-term).

If approved, benefits began on _________________________ Amount of Benefit $______________
(Month/Year)

Important - Attach a copy of the Social Security Award Certificate, Social Security Disability Denial Notice or other correspondence explaining the decision, received from Social Security. If not yet issued, submit a copy when received.

THE FOLLOWING INFORMATION COMPARES THE BENEFITS OF THE THREE TYPES OF DISABILITY AVAILABLE FROM THE MISSOURI HIGHWAY AND TRANSPORTATION EMPLOYEES' AND HIGHWAY PATROL RETIREMENT SYSTEM. PLEASE DATE AND SIGN BELOW TO CERTIFY THAT YOU HAVE READ AND UNDERSTAND THESE PROVISIONS. YOUR SELECTION OF A DISABILITY OPTION IS TO BE MADE ON PAGE 1 OF THIS FORM.

AMOUNT OF BENEFITS

Normal: Average Compensation based on highest 36 consecutive months times one and six-tenths percent (1.6%) times years of creditable service.

Work-Related: Seventy percent (70%) of the compensation you were receiving on the date preceding the date of disability; provided, however, that the amount of the disability benefit plus any primary social security benefits received by such member shall not exceed ninety percent (90%) of the monthly compensation such member was receiving on the date preceding the date of disability.

Long-Term: Sixty percent (60%) of the compensation you were receiving on the date preceding the date of disability *less* any primary social security benefits. The minimum monthly benefit shall be the greater of $50 or fifteen percent (15%) of the monthly benefit before deductions for primary social security benefits and any other employer sponsored income benefits.

3

BENEFIT OFFSETS

1. Workers' Compensation

Normal: The benefit amount shall be decreased by the amount the applicant is receiving or becomes eligible to receive in weekly temporary total disability benefits or continuous permanent total disability benefits. Any lump sum settlement will not be offset.

Work-Related: Same.

Long-Term: Same.

2. Social Security

Normal: No offset.

Work-Related: The benefit amount will be reduced if the combined social security benefit plus seventy percent (70%) of the monthly compensation the member was receiving on the date preceding the date of disability exceeds ninety percent (90%) of compensation.

Long-Term: The benefit amount will be reduced by the amount of primary social security benefits.

REQUIREMENT FOR APPLICATION FOR SOCIAL SECURITY BENEFITS

Normal: Application not required.

Work-Related: You must submit a claim to the Social Security Administration for disability benefits and ***no benefits can be paid until a determination is made on the initial request.*** If the ***initial claim*** is denied, you must request ***reconsideration***. If the claim is again denied, you must request an *appeal*. If you do not provide proof to the system that you have made these requests within 30 days of denial, your benefit will be reduced by the amount you would have received from Social Security had your request been approved.

Long-Term: You must submit a claim to the Social Security Administration for disability benefits and ***no benefits can be paid until a determination is made on the initial request.*** If the ***initial claim*** is denied, you must request ***reconsideration***. If the claim is again denied, you must request an *appeal*. If you do not provide proof to the system that you have made these requests within 30 days of denial, your benefit will be reduced by the amount you would have received from Social Security had your request been approved.

Note: Should your initial request for Social Security benefits be denied and subsequently approved resulting in overpayment from the Highway and Transportation Employees' and Highway Patrol Retirement System, you are required to reimburse the system the amount of overpayment.

CREDITABLE SERVICE

Normal: None.

Work-Related: Continue to accrue creditable service in the retirement system until attaining normal retirement age.

Long-Term: Continue to accrue creditable service in the retirement system until attaining normal retirement age.

4

SURVIVOR'S BENEFITS

Normal: One-half of the member's benefit at the time of death provided the marriage has continued from the effective date of disability benefits.

Work-Related: Same as provided for active employees.

Long-Term: Same as provided for active employees.

COST-OF-LIVING ADJUSTMENT

Normal: Eligible for retiree cost-of-living adjustments of not less than four percent (4%) or more than five percent (5%) each October.

Work-Related: Eligible for retiree cost-of-living adjustments of not less than four percent (4%) or more than five percent (5%) each October.

Long-Term: Not eligible for cost-of-living increases.

Note: All disability recipients will be allowed to keep cost-of-living increases granted by Social Security.

MEDICAL INSURANCE

Normal: If eligible, treated like a retiree, monthly premiums to be paid by the individual.

Work-Related: If eligible, treated like an employee, monthly premium same as for active employees.

Long-Term: If eligible, treated like an employee off the payroll, full premium to be paid by individual without state participation.

LIFE INSURANCE

Normal: $5,000 death benefit from retirement system, up to $10,000 coverage through the optional life insurance state plan, and other life insurance coverages available through MHTD or MSHP.

Work-Related: $5,000 death benefit from retirement system, up to $10,000 coverage through the optional life insurance state plan, and other life insurance coverages available through MHTD or MSHP.

Long-Term: $15,000 of state paid life, up to sixty percent (60%) of the optional life insurance state plan, other life insurance coverage available through MHTD or MSHP.

==

I have read and understand the above statements pertaining to the various categories of disability benefits.

Date______________________________Signature____

Form: P-52 (Physcian)
(Revised 8-28-95)

HIGHWAY AND TRANSPORTATION EMPLOYEES' AND HIGHWAY PATROL RETIREMENT SYSTEM

ATTENDING PHYSICIAN'S STATEMENT

(Please print or type.)

Name______________________________ Social Security No.____________________

Title\ Position______________________________. Attached is a copy of the job description and appropriate analysis forms.

HISTORY

1. When did symptoms first appear or accident happen?______________________________
2. Date patient ceased work because of disability:______________________________
3. Has patient ever had same or similar condition? ( ) Yes ( ) No If yes, state when and describe:

____

____

PRESENT CONDITION

1. Subjective symptoms:____

____

____

2. Objective findings: (Include results of current X-rays, E.K.G.s, or any other special tests)________________

____

____

3. Is patient:
   ( ) Ambulatory ( ) Bed confined ( ) House confined ( ) Hospital confined

DIAGNOSIS

1. Primary diagnosis affecting work ability:
2. Secondary diagnosis affecting work ability:
3. Other known injuries or presently active diseases that may affect work abilities:

TREATMENT

1. Date of first visit:____________________
2. Date of last visit:____________________
   Frequency of visits: ( ) Weekly ( ) Monthly ( ) Other____________________
4. When did you last examine the patient?______________________________
5. Present and future course of treatment:

2

6. Does patient's medical condition allow exposure to the following: please check appropriate box and explain any limitation and extent of limitation below.

	No Limitation	Some Limitation	Avoid Completely	Cannot Determine
Dust/Gases/Fumes	______	______	______	______
Chemicals/Solvents	______	______	______	______
Temperature Extremes	______	______	______	______
Noise Levels	______	______	______	______
Allergenic Agents	______	______	______	______
Stairs/Ladders	______	______	______	______
Scaffolds/Heights	______	______	______	______
Enclosed Spaces	______	______	______	______
Drafts/Damp Areas	______	______	______	______

Explanation:

7. Because of the patient's medical condition, are there any limitations on any of the following activities; please check appropriate box and explain any limitations and the extent of limitation below.

	No Limitation	Some Limitation	Avoid Completely	Cannot Determine
Transportation	______	______	______	______
Standing	______	______	______	______
Sitting	______	______	______	______
Change of Position (sitting/standing)	______	______	______	______
Assuming Cramped/Unusual Positions	______	______	______	______
Reaching (forward/overhead)	______	______	______	______
Pushing/Pulling/Twisting(arm/leg controls)	______	______	______	______
Grasping/Handling	______	______	______	______
Finger Dexterity	______	______	______	______
Repetitive Movement (hands/feet)	______	______	______	______
Climbing (stairs/ladders/scaffolds)	______	______	______	______
Balancing (exposure to falling)	______	______	______	______
Bending/Stooping/Squatting	______	______	______	______
Operating Truck/Dolly/Small Vehicle	______	______	______	______
Operating Heavy Equipment	______	______	______	______
Operating Electrical Equipment	______	______	______	______
Concentrated Visual Attention	______	______	______	______
Other	______	______	______	______

Explanation:

3

8. Evaluation of the patient's carrying and lifting abilities. Please provide an explanation below with any additional comments regarding limitations on duration, ability to handle and distance (in front of body and above floor).

_____ *Sedentary* Work - Exerting up to 10 lbs. of force occasionally (up to 1/3 of the time) and/or negligible amount of force frequently (1/3 - 2/3 of the time) to lift, push, pull, or otherwise move objects. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.

_____ *Light* Work - Exerting up to 20 lbs. of force occasionally (up to 1/3 of the time), and up to 10 lbs. of force frequently (1/3 to 2/3 of the time), or negligible amount of force constantly (2/3 or more of the time). Can walk or stand for a significant amount of time. Can sit most of the time and perform pushing and pulling of the arms and legs.

_____ *Medium* Work - Exerting 20 - 50 lbs. of force occasionally (up to 1/3 of the time), and 10 - 25 lbs. of force frequently (1/3 to 2/3 of the time), and/or up to 10 lbs. of force constantly (2/3 or more of the time) to move objects.

_____ *Heavy* Work - Exerting 50 - 100 lbs. of force occasionally (up to 1/3 of the time), 25 - 50 lbs. of force frequently (1/3 to 2/3 of the time), and/or 10 - 20 lbs. of force constantly (over 2/3 of the time) to move objects.

_____ *Very Heavy* Work - Exerting in excess of 100 lbs. of force occasionally (up to 1/3 of the time), and/or in excess of 50 lbs. of force frequently (1/3 to 2/3 of the time), and/or in excess of 20 lbs. of force constantly (over 2/3 of the time) to move objects.

Explanation:

9. Is there a past or present psychological problem that might interfere with patient's ability to work? If yes, please list your findings according to the DSM-111 multiaxial classification.
Yes ( ) No ( ) Not Determined ( )

____
____
____
____
____

DISABILITY EVALUATION

During the waiting period for long-term and the first 12 full months of benefits under work-related and long-term, "disability" means the employee's physical condition prohibits him/her from performing the essential duties of the employee's normal occupation which is the job or work the employee performed on the date preceding the date of disability and is also unable to perform the essential duties of any occupation commensurate with the employee's education, training, or experience.

1. ( ) Yes ( ) No Is the patient now disabled for his/her normal occupation? If yes, please state the date of disability. ________________________. If no, please state the date the patient will be able to return to duty. ________________________.

2. ( ) Yes ( ) No Is the patient now disabled for <u>any</u> occupation commensurate with the patient's education, training, or experience? If yes, please state the date of disability? ________________________. If no, please state the date the employee would be able to return to other employment. ____________________.

4

3. ( ) Yes ( ) No Is the disability work related? If yes, please state the substantial factors used in your determination.

____
____
____
____
____

4. ( ) Yes ( ) No Is the patient a suitable candidate for a rehabilitation program? Please indicate any additional information that is relevant to the patient's work ability.

____
____
____
____
____

EARNING CAPACITY

Disability benefits shall not be paid to any member who retains or regains his/her earning capacity as determined by the Board. This is defined as an employee's ability to perform any occupation for which the employee is or may reasonably become qualified for by training, education, or experience, to the extent that the employee can earn at least fifty percent (50%) of his/her current annualized rate of pay for the position held by the employee on the date preceding the date of the employee's disability. This criteria is applicable upon the effective date of benefits for normal disability and after monthly benefits have been effective for twelve (12) full months for work-related and long-term disability.

1. ( ) Yes ( ) No In your opinion, has the employee retained or regained 50 percent of his/her earning capacity as described? Please explain:

____
____
____
____
____
____

____
Name of Physician Board Certified Specialty

____
Street Address City or Town State Zip Code

( )____
Telephone Number Date Signature

Form: P-52 (Location)
(Revised 8-28-95)

HIGHWAY AND TRANSPORTATION EMPLOYEES' AND HIGHWAY PATROL RETIREMENT SYSTEM

EMPLOYER'S STATEMENT OF DISABILITY
(To be completed by Division, District, or Troop. Please print or type.)

Name______________________________ Social Security No.________________

Last Day Worked__________________ Job Title____________________________

Date of Disability__________________ Monthly Salary on Date of Disability______________________

Disability Requested: ( ) Normal
( ) Work-related
( ) Long-Term

Effective Date of Benefits__________________

Date accumulated sick leave will be exhausted______________________________

Accumulated vacation and compensatory time will be:
( ) Paid in Lump Sum
( ) Used, date on which it will be exhausted____________________

( )Yes ( ) No Has the employee applied for Workers' Compensation?
( ) Yes ( ) No If yes, is the employee receiving weekly payments from Workers' Compensation?

Please provide your own findings and first-hand observations on how the disability affects his/her ability to perform his/her job duties:______________________________
____
____
____
____
____
____
____
____
____
____

Are there other vacancies in jobs which the employee could perform? ( ) No ( ) Yes, specify which jobs___
____
____
____
____
____
____
____
____
____
____
____

Attach copies of documentation used to determine job eligibility.

Recommendation: ( ) Favorably Considered ( ) Disapproved ( ) Investigated Further

Date____________________ Location______________________________

Title______________________________ Signed______________________________