

Employer Information for Disability Retirement

Section 1

Member Information

To member:
Complete Sections 1
and 2 and forward
to your employer.

Name of Member (First Name, Middle Initial, Last Name)	Social Security Number or CalPERS ID
Position/Occupational Title	Name of Employer/Agency

I have submitted an application for disability retirement with the California Public Employees' Retirement System (CalPERS). I am submitting this letter to you (my employer) on behalf of CalPERS. CalPERS is seeking information to substantiate my disability.

To employer:
Complete Section 3 and
use this form as a cover
sheet to submit requested
documents to CalPERS.

As soon as possible, please send CalPERS the following documents: **job duty statement/job description** for the position I held, **accident reports, medical reports, and personnel records**. These documents must be identified with my name and Social Security number or CalPERS ID. If you have additional comments, please submit them.

CalPERS requires the physical requirements of my position/occupational title. I will be contacting you so we can complete the **Physical Requirements of Position/Occupational Title** form for my position. At that time, a copy of my job duty statement/job description that you send to CalPERS must be provided to me. Both the job duty statement/job description and the **Physical Requirements of Position/Occupational Title** form will be presented to my physician/medical specialist to assist in the evaluation of my disability retirement.

When the CalPERS determination of disability is completed, they will inform you. When you are notified of their determination, you will have the right to appeal the approval/denial of the application for disability retirement for the medical condition stated, in accordance with section 555.3, title II, California Code of Regulations, by filing a written request with CalPERS within 30 days of the mailing of the determination letter. An appeal, if filed, should set forth the factual basis and legal authorities for such appeal.

Under the law, if a person (other than my employer) caused an injury that results in certain CalPERS benefits being paid, CalPERS has the right to recover from the responsible party up to one-half of the total retirement benefit costs payable. This right is known as a "right of subrogation" (Government Code section 20250, et seq.).

Please advise CalPERS if you are aware of any claim (other than a workers' compensation claim) against any person or entity for the same injuries that also entitle me to a disability retirement from CalPERS.

Section 2

Authorization to Release Information

**Send signed authorization
to your employer,
not CalPERS.**

The purpose of this authorization is to assist CalPERS in determining my right to retirement or reinstatement under the Retirement Law, pursuant to Government Code section 20128, and for no other purpose. This authorization will be valid for four years from the date shown below. A photocopy of this authorization shall be as valid as the original.

Signature of Member	Date (mm/dd/yyyy)
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This form continues on page 2.

Section 3

Employer Certification

Pursuant to Government Code section 21156, a disability retirement must not be used as a substitute for the disciplinary process. I hereby certify (check all that apply):

- The member has an adverse action pending against them.
- The member was terminated for cause.
- The member resigned/service retired in lieu of termination.
- The member signed an agreement to waive their reinstatement rights (i.e., Employment Reinstatement Waiver).
- The member is being investigated for or has been convicted of a work-related felony.
- None of the above apply to this member.

Signature of Employer Representative	Date (mm/dd/yyyy)

Print Employer Representative Name	() Phone Number

Position Title of Employer Representative

Mail to:	CalPERS Disability & Survivor Benefits Division • P.O. Box 2796, Sacramento, California 95812-2796
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888 CalPERS (or 888-225-7377) • TTY: (877) 249-7442 • Fax: (800) 959-6545