State of California
California Public Employees' Retirement System
www.calpers.ca.gov

Employer-Originated Disability Retirement Application

Please complete and submit the employer-originated application along with any required documentation to initiate a disability or industrial disability retirement on behalf of the member. Upon receipt of the application, a retirement package will be sent to the member for completion. If the member does not comply, the employer-originated application will be canceled, and both the employer and member will be notified.

Application Type

☐ **Disability Retirement** ☐ **Industrial Disability Retirement**

Section 1: Member Information

Member's Name (First Name, Middle Initial, Last Name) **Member's Social Security Number or CalPERS ID**

Address

City **State** **ZIP** **Country**

Birth Date (mm/dd/yyyy) **Daytime Phone** **Alternate Phone**

Section 2: Member's Spouse or Registered Domestic Partner Information

Spouse or Registered Domestic Partner's Name (First Name, Middle Initial, Last Name) **Date of Marriage (mm/dd/yyyy)**

Section 3: Employment Information

Member's Last Day on Payroll (mm/dd/yyyy) **Member's Full Position Title**

Employer/Agency Name

Is the employee working? ☐ **Yes** ☐ **No**

If yes, in what capacity? ☐ **Full time** ☐ **Part time** ☐ **Modified Duties**

Pursuant to Government Code section 21156, a disability retirement must not be used as a substitute for the disciplinary process.

Does the employee have a pending "Adverse Action" against them?	☐ Yes	☐ No
Was the employee terminated for cause?	☐ Yes	☐ No
Did the employee resign/service retire in lieu of termination?	☐ Yes	☐ No
Did the employee sign an agreement to waive their reinstatement rights?	☐ Yes	☐ No
Is the employee being investigated for, or have they been convicted of, a work-related felony?	☐ Yes	☐ No

If you answered "yes" to any of the questions, provide a copy of the following documentation: Personnel Records, Adverse Actions, SPB Decisions, and Investigative Reports.

Member's Name **Social Security Number or CalPERS ID**

Section 4: Disability Information

Provide a copy of the following documentation: Job Duty Statement, ***Physical Requirements of Position/Occupational Title*** form (available on the CalPERS website), and Medical Information to support application (e.g., Fitness for Duty Reports, Doctor's Notes, etc.).

What is the member's specific disability?

Section 5: Workers' Compensation Detail

For additional claim numbers and information, please attach a separate sheet and be sure to include the member's Social Security number or CalPERS ID.

Does the member have any workers' compensation claims? ○ **Yes** ○ **No**

Claim Number(s) **Date of Injury (mm/dd/yyyy)**

Body Part(s) **Liability Accepted?** ○ **Yes** ○ **No**

Workers' Compensation Carrier

Adjuster: First Name **Last Name**

Phone Number **Fax** **Email**

Address of Workers' Compensation Claim Carrier

City **State** **ZIP**

Section 6: Employer Certification

I certify to the best of my knowledge that the information provided on this application is true and correct.

Signature of Employer Representative

Print Employer Representative Name

Position Title of Employer Representative **Phone Number** **Date (mm/dd/yyyy)**

Mail to: CalPERS Disability & Survivor Benefits Division, P.O. Box 2796, Sacramento, CA 95812-2796

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used to conduct CalPERS Board of Administration duties under the Public Employees' Retirement Law, the Social Security Act, and/or the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to submit the required information may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/ employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the System. For questions about this notice, our Privacy Policy, or your rights, write to:

CalPERS
CalPERS Privacy Officer
400 Q Street, Sacramento, CA 95811

You may also call us at **888 CalPERS** (or **888**-225-7377).