Teachers Retirement Association

60 Empire Drive • Suite 400 • St Paul MN 55103-4000
651.296.2409 • 800.657.3669 • 651.297.5999 FAX • 800.627.3529 TTY

Submit to TRA by mail or FAX (original is not required).

Disability Benefit Application

According to TRA retirement law, total and permanent disability means the inability to engage in any substantial, gainful employment because a medically proven physical or mental impairment exists and is expected to last at least one year.

Please provide this information to help us determine your eligibility for a disability benefit. Although you are not required by law to provide this information, we will be unable to determine your eligibility or make disability payments, if applicable, to your correct address without it. Except for your name and city, the information on this form is private. No private data will be shared with any unauthorized person or organization without your informed written consent.

Member Name		Social Security Number	TRA Number
Address	City	State Zip	Telephone Number
Date of Birth	Name of Spouse (if applicable)		Spouse's Date of Birth

1. Define your disability.

2. List physicians or clinics familiar with your condition.

Physician/Clinic	Address	City	State	Zip	Date

3. List any hospitalization required by this disability.

Hospital	Address	City	State	Zip	Date

4. List any surgery related to your disability.

Type	Surgeon	Address	City	State	Zip	Date

5. Most recent employer (district/county/city/dept). _____

6. Date when first impaired. _____ Date last check was received. _____

7. Last day of service or leave, whichever is later, for which salary was paid. _____

8. Indicate your status with respect to workers' compensation benefits.

☐ Receiving benefits ☐ Applying for benefits ☐ Approved for benefits ☐ Did not apply ☐ Denied benefits

9. Indicate your status as it relates to Social Security disability benefits.

☐ Receiving benefits ☐ Applying for benefits ☐ Approved for benefits ☐ Did not apply ☐ Denied benefits

10. List any membership in other Minnesota public retirement systems (e.g., PERA, MSRS) and coverage dates.

11. You may choose to receive an optional annuity instead of a disability benefit. The monthly amount payable will depend on the annuity plan you elect. Please refer to your attached estimate letter for personal estimates and a description of the optional plans. Please see the "Election of an Optional Annuity" section in the TRA Disability Coverage booklet or contact TRA if you have questions regarding an optional annuity. Do you wish to receive an application for an optional annuity instead of a disability benefit? ☐ Yes ☐ No

12. Member Signature

I authorize and direct any physician, chiropractor, psychologist, hospital, agency or other organization to disclose all information that it may possess to verify my disability claim. I affirm that the statements in this application are complete and true.	Signature of Member	Date

13. Spouse Signature

I am the spouse of the previously named employee. I am aware of the annuity options that are available to protect me, and I have read and understand the decision of my spouse.	Signature of Spouse	Date

If you have questions, please call our Customer Service Information Center at 651-296-2409 or 800-657-3669.
This application is available in alternate formats upon request.