TRA | TEACHERS RETIREMENT ASSOCIATION

60 Empire Drive • Suite 400
Saint Paul Minnesota 55103
800 657 3669 • fax 651 297 5999

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

Disability Benefit Application

According to current 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 complete 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. 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	Date of Birth	TRA Number
Address	Telephone Number	
	Email Address	
Name of Spouse (if applicable)	Spouse's Date of Birth	

1. Define your disability.

2. List physician or clinic details that are relevant to your disability.

Physician/Clinic	Address	City	State	Zip	Date

3. List any hospitalization details that are relevant to your disability.

Hospital	Address	City	State	Zip	Date

4. List any surgery details that are relevant to your disability.

Type	Surgeon	Address	City	State	Zip	Date

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

6. Date when you were first impaired: _____ Last paycheck receipt date: _____

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

8. Indicate your status with respect to workers' compensation benefits: (Must check one)

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

9. Indicate your status with respect to veteran's disability benefits: (Must check one)

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

10. Indicate your status as it relates to Social Security disability benefits: (Must check one)

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

11. Do you have membership with one or more of the following Minnesota pension funds?
    - Public Employees Retirement Association (PERA)
    - Minnesota State Retirement System (MSRS)
    - St. Paul Teachers' Retirement Fund Association (SPTRFA)

☐ Yes ☐ No

12. You may choose to receive an optional annuity instead of a disability benefit. The monthly amount payable depends on the annuity plan you select. Refer to your attached estimate letter for personal estimates and a description of the optional annuity plans. Refer to the "Election of an Optional Annuity" section in the TRA *Disability Coverage* booklet or contact TRA if you have questions regarding the annuity plans. Do you wish to receive an application for an optional annuity instead of a disability benefit? (Must check one.)

☐ Yes ☐ No

13. A. Is your insurance company forcing you to apply for a disability benefit with TRA? (Must check one.)

☐ Yes ☐ No

B. Would you have applied for disability with TRA if your insurance company did not force you to apply? (Must check one.)

☐ Yes ☐ No

Note: If you answered “Yes” to 13A and “No” to 13B please send TRA a copy of your insurance policy.

14. 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

15. 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 any questions, visit us at www.MinnesotaTRA.org or contact TRA at 651-296-2409 or 800-657-3669.