TEACHERS' RETIREMENT FUND (TRF) ATTENDING PHYSICIAN STATEMENT FOR A CLASSROOM DISABILITY BENEFIT

State Form 17296 (R9 / 3-25)

Reset Form

INDIANA PUBLIC RETIREMENT SYSTEM
TEACHERS' RETIREMENT FUND
One North Capitol Avenue, Suite 001
Indianapolis, IN 46204-2014
Telephone: (844) GO-INPRS (844-464-6777) (Toll-free)
Fax: (317) 232-3882
E-mail: questions@inprs.in.gov
Web site: www.inprs.in.gov

INSTRUCTIONS

1. This form must be delivered by the applicant to the member's attending physician.
2. This form must be completed, signed, and dated by the member's attending physician and mailed by the attending physician to the Fund physician. In compliance with Health Information Portability and Accountability Act (HIPAA) regulations, this form cannot be faxed or e-mailed because of the personal health information (PHI) contained in the document.
3. The applicant must make any payments necessary to complete this statement.
4. This statement must be filed before a disability application will be considered.

This form is required as part of the application for a Classroom Disability benefit and is required for the annual review of the member's continued eligibility for the Classroom Disability benefit. The process for initiating or continuing a Classroom Disability benefit is as follows:

1. The *Teachers' Retirement Fund (TRF) Attending Physician Statement for a Classroom Disability Benefit (State Form 17296)* must be completed by the member's personal physician.
2. After completion, the *Teachers' Retirement Fund (TRF) Attending Physician Statement for a Classroom Disability Benefit (State Form 17296)* must be sent by the member's attending physician directly to the Fund physician (appointed by the Indiana Public Retirement System (INPRS) Board of Trustees and named in the cover letter sent with this form).
3. The Fund physician appointed by INPRS reviews the completed *Teachers' Retirement Fund (TRF) Attending Physician Statement for a Classroom Disability Benefit (State Form 17296)* and makes a determination as to the member's eligibility or continued eligibility for a Classroom Disability benefit.
4. The Fund physician reports the determination of eligibility or continued eligibility for the Classroom Disability benefit to the Fund.
5. INPRS notifies the member of the member's eligibility for a classroom disability benefit or of continued eligibility based on the recommendation of the Fund physician.
6. If the *Teachers' Retirement Fund (TRF) Attending Physician Statement for a Classroom Disability Benefit (State Form 17296)* is being requested as part of the annual review for continuation of the Classroom Disability benefit, the final determination from the Fund physician must be received by INPRS within sixty (60) days. If the final determination is not received within the required sixty (60) days, the member's Classroom Disability benefit is to be suspended until the final determination is received

GENERAL INFORMATION

IC 5-10.4-5-1(b) A member who is an active teacher, has earned at least five (5) service credits, and suffers a temporary or permanent disability that continues for at least six (6) months may receive a classroom disability benefit for as long as the disability exists.

35 IAC 14-1-4 A classroom disability refers to a medically confirmed inability to continue classroom teaching due to a mental or physical condition that is not necessarily of sufficient severity to meet Social Security disability guidelines.

35 IAC 14-9-1(c) A member's continuing eligibility for classroom disability benefits shall be reviewed on an annual basis.

If, with reasonable accommodations made by the employer, the member is able to perform the essential elements of the member's job, the member is not considered to be disabled from teaching and therefore does not qualify for a Classroom Disability benefit. As an example, the inability to drive to and from work is not justification for a disability determination if the member can otherwise perform the necessary teaching functions.

NOTE: This form must be completed, signed, and submitted to INPRS no later than one year after the date of disability in order to receive credit (IC 5-10.4-5-1). If the member files for classroom disability more than a year after the disability diagnosis, the member must submit a letter stating why they did not file within one year. The letter must include any copies of supporting documentation and information about injury or illness or other extenuating circumstances that caused the delay.

TEACHERS' RETIREMENT FUND (TRF) ATTENDING PHYSICIAN STATEMENT FOR A CLASSROOM DISABILITY BENEFIT

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MEMBER INFORMATION		
Member name	Pension ID (PID)number	Date of birth (*mm/dd/yyyy*)
Address *(number and street)*	Telephone number with area code	
City	State	ZIP Code

MEMBER AUTHORIZATION	
I hereby make initial/renewal application for Classroom Disability benefits under the provisions of IC 5-10.4-5-1(b). I hereby authorize my physician to release such medical records as are necessary for this determination to the board-approved reviewing physician.	
Member signature	Date *(mm/dd/yyyy)*

PATIENT HISTORY				
This section must be completed by the attending physician in the handwriting of the attending physician and mailed by him/her to the Indiana Public Retirement System Board of Trustees' physician for review.				
How long have you been the physician for the patient?		Date of your first visit with the patient for illness claimed to have brought about the present condition (*mm/dd/yyyy*).		
Number of visits	Date of last visit (*mm/dd/yyyy*)	Patient height in inches	Patient weight in pounds	Patient blood pressure

What organ(s), system(s), or part(s) of the body have been affected?

Fully describe the course of the disease, its initial symptoms, and the history of its progress.

Has the patient suffered from any ailments other than those mentioned above? ☐ Yes ☐ No
If Yes, describe each case and state the duration of the ailment and if recovery was complete.

Has the patient been attended to or prescribed for any other physician or surgeon within three (3) years? ☐ Yes ☐ No
If Yes, for what reason? Provide the names and addresses of all such physicians and surgeons.

TEACHERS' RETIREMENT FUND (TRF) ATTENDING PHYSICIAN STATEMENT FOR A CLASSROOM DISABILITY BENEFIT

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Member name	Pension ID (PID)number	Date of birth (*mm/dd/yyyy*)

PATIENT HISTORY *(Continued)*

Is the patient wholly and continuously unable to perform the work of a school teacher? ☐ Yes ☐ No

If Yes, is the disability, in your opinion, likely to be temporary, permanent and total, or permanent and partial?

List specific reasons why you consider the patient to be unable to perform the work of a school teacher.

ATTENDING PHYSICIAN INFORMATION

Attending physician name		
Address *(number and street)*	Telephone number with area code	
City	State	ZIP Code
How long have you been a licensed physician?	Where did you receive your medical education?	
Attending physician signature		Date *(mm/dd/yyyy)*

Upon completion, including the attending physician's signature, date signed, and printed name and address, forward this document to the physician appointed by the Indiana Public Retirement System Board of Trustees. The physician's name and address are included in the cover letter accompanying this form.

INSTRUCTIONS FOR

TEACHERS' RETIREMENT FUND (TRF) ATTENDING PHYSICIAN STATEMENT FOR A CLASSROOM DISABILITY BENEFIT

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IMPORTANT

1. This form must be delivered by the applicant to the member's attending physician.
2. This form must be completed, signed, and dated by the member's attending physician and mailed by the attending physician to the Fund physician. In compliance with Health Information Portability and Accountability Act (HIPAA) regulations, this form cannot be faxed or e-mailed because of the personal health information (PHI) contained in the document.
3. The applicant must make any payments necessary to complete this statement.
4. This statement must be filed before a disability application will be considered.

This form is required as part of the application for a Classroom Disability benefit and is required for the annual review of the member's continued eligibility for the Classroom Disability benefit. The process for initiating or continuing a Classroom Disability benefit is as follows:

1. The *Teachers' Retirement Fund (TRF) Attending Physician Statement for a Classroom Disability Benefit (State Form 17296)* must be completed by the member's personal physician.
2. After completion, the *Teachers' Retirement Fund (TRF) Attending Physician Statement for a Classroom Disability Benefit (State Form 17296)* must be sent by the member's attending physician directly to the Fund physician (appointed by the Indiana Public Retirement System (INPRS) Board of Trustees and named in the cover letter sent with this form).
3. The Fund physician appointed by INPRS reviews the completed *Teachers' Retirement Fund (TRF) Attending Physician Statement for a Classroom Disability Benefit (State Form 17296)* and makes a determination as to the member's eligibility or continued eligibility for a Classroom Disability benefit.
4. The Fund physician reports the determination of eligibility or continued eligibility for the Classroom Disability benefit to the Fund.
5. INPRS notifies the member of the member's eligibility for a classroom disability benefit or of continued eligibility based on the recommendation of the Fund physician.
6. If the *Teachers' Retirement Fund (TRF) Attending Physician Statement for a Classroom Disability Benefit (State Form 17296)* is being requested as part of the annual review for continuation of the Classroom Disability benefit, the final determination from the Fund physician must be received by INPRS within sixty (60) days. If the final determination is not received within the required sixty (60) days, the member's Classroom Disability benefit is to be suspended until the final determination is received.

Entry field	Field description
INSTRUCTIONS	
Read the INSTRUCTIONS section to understand what is being requested and what must be submitted.	
GENERAL INFORMATION	
IC 5-10.4-5-1(b) A member who is an active teacher, has earned at least five (5) service credits, and suffers a temporary or permanent disability that continues for at least six (6) months may receive a classroom disability benefit for as long as the disability exists. 35 IAC 14-1-4 A classroom disability refers to a medically confirmed inability to continue classroom teaching due to a mental or physical condition that is not necessarily of sufficient severity to meet Social Security disability guidelines. 35 IAC 14-9-1(c) A member's continuing eligibility for classroom disability benefits shall be reviewed on an annual basis. If, with reasonable accommodations made by the employer, the member is able to perform the essential elements of the member's job, the member is not considered to be disabled from teaching and therefore does not qualify for a Classroom Disability benefit. As an example, the inability to drive to and from work is not justification for a disability determination if the member can otherwise perform the necessary teaching functions. **NOTE**: This form must be completed, signed, and submitted to INPRS no later than one year after the date of disability in order to receive credit (IC 5-10.4-5-1). If the member files for classroom disability more than a year after the disability diagnosis, the member must submit a letter stating why they did not file within one year. The letter must include any copies of supporting documentation and information about injury or illness or other extenuating circumstances that caused the delay.	
MEMBER INFORMATION	
Read the statements in this section then sign and date the page.	
Member name	Enter the complete name of the member. The member name and PID and Date of birth must be entered on each page submitted to INPRS.
Pension ID (PID) number	Enter the member's Pension ID (PID) number.
Date of birth	Enter the member's date of birth. Format = mm/dd/yyyy.
Address, City, State, ZIP Code	Enter the member's mailing address.
Telephone number	Enter the member's telephone number with area code.
MEMBER AUTHORIZATION	
Member signature	This form must be signed and dated by the member.
Date	This form must be signed and dated by the member. Format = mm/dd/yyyy.

INSTRUCTIONS FOR

TEACHERS' RETIREMENT FUND (TRF) ATTENDING PHYSICIAN'S STATEMENT FOR A CLASSROOM DISABILITY BENEFIT

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Entry field	Field description
PATIENT HISTORY	
This section must be completed by the attending physician in the handwriting of the attending physician and mailed by him/her to the Indiana Public Retirement System Board of Trustees' physician for review.	
How long have you been the physician for the patient?	Enter the length of time and any applicable explanation if needed.
Date of your first visit with the patient for illness claimed to have brought about the present condition.	Enter the date (mm/dd/yyyy) and any applicable explanation if needed.
Number of visits	Enter the number of visits you have had with this patient.
Date of last visit	Enter the date of the last visit with this patient. Format = mm/dd/yyyy.
Patient height in inches	Enter the patient's height in inches.
Patient weight in pounds	Enter the patient's weight in pounds.
Patient blood pressure	Enter the patient's blood pressure.
What organ(s), system(s), or part(s) of the body have been affected?	Enter an explanation of the organ, system, or parts of the patient's body have been affected.
Fully describe the course of the disease, its initial symptoms, and the history of its progress.	Enter the requested information and any applicable explanation.
Has the patient suffered from any ailments other than those mentioned above?	Select Yes or No. If Yes, describe each case and state the duration of the ailment and if recovery was complete.
Has the patient been attended to or prescribed for any other physician or surgeon within 3 years?	Select Yes or No. If Yes, for what reason? Provide the names and addresses of all such physicians and surgeons.
Is the patient wholly and continuously unable to perform the work of a school teacher?	Select Yes or No. If Yes, is the disability, in your opinion, likely to be temporary, permanent and total, or permanent and partial?
List specific reasons why you consider the patient to be unable to perform the work of a school teacher.	Provide a list of reasons and any applicable explanations.
ATTENDING PHYSICIAN INFORMATION	
Upon completion, including the attending physician's signature, date signed, and printed name and address, forward this document to the physician appointed by the Indiana Public Retirement System Board of Trustees. The physician's name and address are included in the cover letter accompanying this form.	
Attending physician name	Enter the complete name of the attending physician.
Address, City, State, and ZIP Code	Enter the mailing address for the attending physician.
How long have you been a licensed physician?	Enter the number of years and any other explanation as needed.
Where did you receive your medical education?	Enter the institution(s) where you received your medical education.
Attending physician signature	This form must be signed and dated by the attending physician.
Date	This form must be signed and dated by the attending physician. Format = mm/dd/yyyy.