AFFIDAVIT OF APPLICANT FOR CLASSROOM DISABILITY BENEFIT

State Form 21703 (R8 / 1-18)

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

* This agency is requesting disclosure of Social Security Numbers in accordance with Internal Revenue Code 3405; disclosure is mandatory and this form cannot be processed without it.

INSTRUCTIONS

1. Read the application before entering information on the application.
2. Type or print using black ink. Complete all information and place the Member's name, Social Security number (last 4 digits), and Pension ID (PID) number at the top of each page as requested.
3. Direct questions to Customer Service, Toll-free at (844) GO-INPRS, Monday – Friday, 8 a.m.- 8 p.m. EST. The agency is closed on weekends and State-approved holidays.

IMPORTANT INFORMATION

1. The member must complete the information requested in this affidavit and provide this completed affidavit and the *Attending Physician's Statement for a Classroom Disability Benefit* (State Form 17296) to **the member's attending physician**.
2. 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 member's attending physician must submit this completed affidavit and the completed *Attending Physician's Statement for a Classroom Disability Benefit* (State Form 17296) **to the Fund physician** appointed by the INPRS Board of Trustees.
4. The Fund physician reviews the documents and makes a determination that is then provided to the INPRS, Teachers' Retirement Fund (TRF).
5. TRF notifies the member of the determination.

MEMBER INFORMATION

Member's name			Social Security number *(last 4 digits)**	Pension ID (PID) number
Address *(number and street)*			Date of birth *(mm/dd/yyyy)*	Telephone number with area code
City	State	ZIP Code	E-mail address	

LAST EMPLOYER INFORMATION

Last employer		Employer city or township	Employer county
Last date of active teaching service *(mm/dd/yyyy)*	Last teaching position	Date covered service began *(mm/dd/yyyy)*	Member's age at beginning service

President of Board or Trustee of last employer			Superintendent of last employer		
Address of President of Board or Trustee of last employer			Address of Superintendent of last employer		
City	State	ZIP Code	City	State	ZIP Code

MEDICAL INFORMATION

Date medical condition began *(mm/dd/yyyy)*	Date you gave up your teaching position *(mm/dd/yyyy)*	Date you first consulted a physician for this condition *(mm/dd/yyyy)*	Date your last school year ended *(mm/dd/yyyy)*
Date your next school year starts *(mm/dd/yyyy)*	Date a half school year will have elapsed since you quit teaching *(mm/dd/yyyy)*	Time lost during last teaching year because of your condition	Earnings, if any, since you ceased public school work
Name of attending physician you first consulted for this condition		Address of attending physician	
How did your disability begin? State fully all the symptoms and describe your condition from onset of symptoms:			
Are you confined to bed? ☐ Yes ☐ No	Are you confined to a house? ☐ Yes ☐ No	Date confinement, if any, began *(mm/dd/yyyy)*	Do you expect such confinement to continue? ☐ Yes ☐ No

Member's name	Social Security number *(last 4 digits)**	Pension ID (PID) number

MEDICAL INFORMATION *(Continued)*

Describe, in detail, to what extent you are incapacitated from continuing in the teaching profession.

What ailments, diseases, illnesses, disorders, infirmities, disabilities or injuries have you had in the last five years? Give complete facts, dates of onset, and the name and address of any physician who attended you in each case.

Have you ever been an inmate of a hospital, asylum, sanitarium, or health resort of any kind? If so, give dates, sites, and full particulars.

During the last five years have you received a pension from any source, or benefits from any accident or health insurance company or association? If so, provide dates, names, addresses and full particulars.

Give name and address of every physician and/or specialist you have consulted during the last three years.

Have you made claim to any insurance company for benefits because of your condition? If so, give name and address of each such insurance company.

Are you able to appear before the examining physician in Indianapolis? ☐ Yes ☐ No

If not, can you appear before an examining physician in your area? ☐ Yes ☐ No

MEMBER AFFIDAVIT

I hereby acknowledge that I understand the terms of this affidavit and any ambiguities herein are to be resolved in favor of the Teachers' Retirement Fund. I hereby acknowledge that I have had ample time and opportunity to secure legal counsel for the purpose of explaining any of these declarations contained within. I affirm, under the penalties for perjury, that the foregoing representation(s) is (are) true.

Member's signature	Member's name (*printed*)	Date *(mm/dd/yyyy)*

NOTARY PUBLIC CERTIFICATION

State of ________________________________

SS:

County of ______________________________

Before me the undersigned, a Notary Public for __________________________ County, State of _________________________,
Officer's county of residence / Officer's state of residence

personally appeared _____________________________________ and he/she, being first duly sworn by me upon his/her oath,
Name of person

say that the facts alleged in the foregoing instrument are true.

SEAL

Signed and sealed this _______ day of _____________, 20_______. ____________________________________
Signature

My commission expires: ___________________________________ ____________________________________
Date *(mm/dd/yyyy)* / Name of officer *(printed or typed)*

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3. Questions or changes? Call customer service, toll-free, at (844) GO-INPRS, Monday – Friday, 8 a.m.- 8 p.m. EST.

IMPORTANT INFORMATION

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5. TRF notifies the member of the determination.

Entry field	Field description
MEMBER INFORMATION	
Member name	Enter the member's complete name.
Social Security number	Enter the last 4 digits of the member's Social Security number.
PID number	Enter the member's personal identification (PID) number.
Address	Enter the member's street or mailing address.
Date of birth	Enter the member' date of birth; format = mm/dd/yyyy.
Telephone number	Enter the member's telephone number with area code.
City, State, ZIP code	Enter the member's city, state, and ZIP Code.
E-mail address	Enter the member's e-mail address.
LAST EMPLOYER INFORMATION	
Last employer	Enter the name of the member's last employer (school corporation).
Employer city or township	Enter the location city and/or township of the member's last employer.
Employer county	Enter the county location of the member's last employer.
Last date of active teaching service	Enter the last date of active teaching service with the last employer; format = mm/dd/yyyy.
Last teaching position	Enter the title of the last teaching position with the last employer.
Date covered service began	Enter the date the covered service began with the last employer; format = mm/dd/yyyy.
Member's age at beginning service	Enter the member's age at the beginning of covered service.
President of Board or Trustee of last employer	Enter the name of the board president or trustee for the last employer.
Superintendent of last employer	Enter the name of the superintendent for the last employer.
Address of President of Board or Trustee of last employer	Enter the contact address for the board president or trustee for the last employer.
Address of Superintendent of last employer	Enter the contact address for the superintendent for the last employer.
MEDICAL INFORMATION	
Date medical condition began	Enter the beginning date of the medical condition; format = mm/dd/yyyy.
Date you gave up your teaching position	Enter the final teaching date; format = mm/dd/yyyy.
Date you first consulted a physician for this condition	Enter the date of initial consultation for the medical condition; format = mm/dd/yyyy.
Date your last school year ended	Enter the end date for the last school year; format = mm/dd/yyyy.
Date your next school year starts	Enter the begin date for the next school year; format = mm/dd/yyyy.
Date a half school year will have elapsed since you quit teaching	Enter the date which marks one half school year after final teaching date; format = mm/dd/yyyy.
Time lost during last teaching year because of your condition	Enter the time lost during last teaching year due to the medical condition.
Earnings, if any, since you ceased public school work	Enter the amount of earnings after the end of public school work.
Name of attending physician you first consulted for this condition	Enter the name of the doctor from initial consultation.
Address of attending physician	Enter the address of the doctor from initial consultation.
How did your disability begin?	Enter all the symptoms and describe condition since the symptoms began.
Are you confined to bed?	Check Yes or No.
Are you confined to a house?	Check Yes or No.

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Entry field	Field description
Date confinement, if any, began	Enter the beginning date of confinement; format = mm/dd/yyyy.
Do you expect such confinement to continue?	Check Yes or No.
Describe, in detail, to what extent you are incapacitated from continuing in the teaching profession.	Describe the extent of incapacitation.
What ailments, diseases, illnesses, disorders, infirmities, disabilities, or injuries have you had in the last five years?	List all ailments in the last five years.
Have you ever been an inmate of a hospital, asylum, sanitarium, or health resort of any kind?	List any health facility stays.
During the last five years have you received a pension from any source, or benefits from any accident or health insurance company or association?	List all pension or benefit payments received during the last five years.
Give name and address of every physician and/or specialist you have consulted during the last three years.	List all physicians consulted during the medical condition.
Have you made claim to any insurance company for benefits because of your condition?	List all insurance claims for the medical condition.
Are you able to appear before the examining physician in Indianapolis?	Check Yes or No.
If not, can you appear before an examining physician in your area?	Check Yes or No.
MEMBER AFFIDAVIT	
Member's signature and date	This form must be signed and dated by the member; format = mm/dd/yyyy.
Member's name	This is the member's printed name.
NOTARY PUBLIC CERTIFICATION	
This form must be notarized before it can be processed by INPRS. Take the form to a Notary Public with an active commission. The Notary will require that you swear or affirm that you are the named person on the form. You will be required to sign and date the form in the Notary's presence. The notary must then complete the NOTARY PUBLIC CERTIFICATION section of the form and affix the Notary's seal.	