City of Tacoma
Tacoma Employees' Retirement System (TERS)
3628 S. 35th St., Tacoma, WA 98409 ▪ P.O. Box 11007, Tacoma, WA 98411-0007

Office: (253) 502-8200
Fax: (253) 502-8660

Application For Disability Retirement Part 1
Member Information

Applicant Information				**Employee no.**________________________	
First Name	Middle Initial	Last Name		Social Security Number	
Mailing Address		City		State	Zip Code
Telephone Number	E-mail		Date of Birth		
Marital Status ☐ Single ☐ Married	Title of Position		Department		
Are you re-applying? ☐ Yes ☐ No	*(Office Use Only)* Date of Separation:		Re-apply Expiration Date:		

☐ My incapacity for the performance of my duties was caused directly by an accident or event or incurred as a result of the actual performance of duties as an employee of the City of Tacoma.

☐ My disability is caused by the following medical condition(s). If more than one disabling condition exists, specify each:

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I understand that as an applicant for disability retirement benefits I am responsible for providing, at my expense, medical evidence showing the nature and extent of my disability. As part of my application, I will be required to undergo an independent medical evaluation. I may be required to have additional independent medical evaluations if I qualify for and begin receiving disability retirement.

I authorize any physician, hospital, agency or other organization to disclose to the TERS office any medical records or other information (including paper, mail and electronic interchange) about my disability. These records may be reviewed as needed by an independent medical examiner, and by TERS staff, only as needed in order to process my disability retirement. I authorize the TERS Office to obtain copies of any related records from the City's Risk management and Workers Compensation files.

I understand that my express consent is required to release any health care information relating to industrial insurance, testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have applied for industrial insurance and/or been tested, diagnosed, or treated for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, any physician, hospital, agency or other organization is specifically authorized to release all health care information relating to such diagnosis, testing or treatment as they pertain to my claimed disability.

My consent to release the above referenced information remains valid from the date I submit my application throughout the duration of my disability retirement. I may revoke this release at anytime by submitting a request in writing to TERS, however revoking this release may affect any disability benefits that I am, or may receive from TERS.

I attest that all statements on this form are true and correct.

Signature ____ Date ____________