TRSL Teachers' Retirement System of Louisiana

Application for Disability Retirement
(Form 12)

08-12
rev. 09/25

HOW TO SUBMIT:	DROP OFF or MAIL IN	EMAIL	FAX
	8401 United Plaza Blvd, Ste 300 Baton Rouge LA 70809	*web.master@trsl.org*	(225) 925-6366

TRSL USE ONLY
Employer number
Date of receipt:
Approved by:

Print or type all entries below, except signatures. Please read this application carefully before signing. It is the applicant's responsibility to ensure that this application and all other required documents are submitted to TRSL. State law sets forth timelines for review of applications for disability retirement. As a result, members are encouraged to submit with this application all additional required documents for the State Medical Disability Board (SMDB) physician's review, including Form 12A or 12C and all medical records. Otherwise, these documents must be submitted no later than thirty (30) days from the filing of this application (Form 12). If approved for TRSL disability retirement benefits by the SMDB, TRSL-covered employment must cease immediately and cannot extend beyond the SMDB-approval date, unless exhausting sick or annual leave. The effective date of your disability retirement will be the date TRSL receives your disability application or the day after you terminate employment, whichever is later.

IMPORTANT: Retirees receiving a TRSL disability benefit cannot return to work in the field of public or private education; doing so will result in the termination of their disability benefits, as required by state law. Also note that disability retirees who convert to service (regular) retirement become subject to the state's return-to-work law requirements, which are different from requirements for disability retirees. *This application may serve as a service retirement application if it is not approved and you meet regular retirement eligibility requirements.*

Section 1 - Member information (MUST BE COMPLETED)

Name: Last, first, MI, suffix (Jr., III, etc.)		Your Social Security number (*Attach copy of card*)
Street address / PO box	City, state, zip	
Daytime telephone (include area code)	Email address	Estimated benefits will be processed after we receive a copy of your card.

Check one: ☐ Not married ☐ Married	Have you ever been divorced? ☐ Yes ☐ No	Date of birth (*Attach proof of birth date*)
Spouse's name: Last, first, MI, suffix (Jr., III, etc.)	Spouse's date of birth (*Attach proof of birth date*)	Spouse's Social Security number (*Attach copy of card*)

Section 2 Workers' Compensation information

Are you now or have you ever received Workers' Compensation while a member of TRSL? ☐ Yes ☐ No

If yes, are you receiving this benefit due to the disabling condition? ☐ Yes ☐ No

Amount of benefit $ ____ ☐ Weekly ☐ Biweekly ☐ Monthly

Section 3 - Beneficiary information (if no beneficiary is desired, enter "no beneficiary.") DO NOT LEAVE BLANK.

	Name: Last, first, MI, suffix (Jr., III, etc.)	Relationship	Date of birth (*mm/dd/yyyy*) - Attach proof	Social Security number - *Attach copy of card*
1)				
2)				
3)				
4)				

You can designate a specific monthly survivor benefit for your beneficiary. You must specify a monthly amount at right in order to be provided with calculated amounts under Options 4 and 4A on your Affidavit of Retirement Option Election.

Option 4 and 4A monthly survivor benefit $ ____ 00

Section 4 - Minor and other eligible children - ONLY IF ORIGINAL PLAN MEMBER

	Name: Last, first, MI, suffix (Jr., III, etc.)	Date of birth (*mm/dd/yyyy*)	Does child have a permanent disability?	Social Security number - *Attach copy of card*
1)			☐ Yes ☐ No	
2)			☐ Yes ☐ No	
3)			☐ Yes ☐ No	
4)			☐ Yes ☐ No	

Complete reverse side.

Social Security number

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Section 5 - Description of condition (to be completed by member)

1. Approximately when did your disability begin (*mm/dd/yyyy*)

2. Title of position

3. Describe the nature of your disabling condition:

4. Describe your job duties and how your disabling condition affects your ability to perform your job:

5. Reports regarding your disabling condition will be submitted by the following physicians. (If additional space is needed, attach additional sheets.):

Name of physician	Area of specialty	Daytime phone number (*include area code*)
1)		
Name of physician	Area of specialty	Daytime phone number (*include area code*)
2)		
Name of physician	Area of specialty	Daytime phone number (*include area code*)
3)		
Name of physician	Area of specialty	Daytime phone number (*include area code*)
4)		

6. Regarding your disability, what is your consulting physician's major area of specialty? This will determine the State Medical Disability Board physician that will review your medical records.

☐ Cardiology ☐ Neurology ☐ Orthopedics ☐ Other (specify): _____

☐ Internal Medicine ☐ Oncology ☐ Psychiatry

Section 6 Applicant and witness signatures (*Witnesses may not be named beneficiaries*.)

I hereby certify that all information contained on this application is true and correct as of the date of my signature on this form. I understand that I should receive an acknowledgment letter by mail within approximately one (1) week of TRSL's receipt of my application. If I do not receive this acknowledgment letter, I will contact TRSL. I agree to submit all medical information relevant to my application for disability retirement and copies of my relevant personnel records, if required by the SMDB. Furthermore, I understand that upon notice of the approval of my disability retirement application, I must terminate employment immediately, unless I am exhausting leave, pursuant to LSA.R.S. 11:218(E). (*Witness signatures are only required if applicant is unable to sign*.)

Applicant's signature (DO NOT PRINT OR TYPE) ▶	Date signed (*mm/dd/yyyy*)
Witness's signature (DO NOT PRINT OR TYPE) ▶	Witness's signature (DO NOT PRINT OR TYPE) ▶