Teachers' Retirement System of Louisiana
PO Box 94123 • Baton Rouge, LA 70804-9123
Telephone: (225) 925-6446 • Fax: (225) 925-6366
Toll free (outside Baton Rouge area): 1-877-275-8775
www.TRSL.org • *web.master@trsl.org*

Form 12 (6/20)

TRSL use only
Employer number
Date of receipt
Approved by:

Application for Disability Retirement

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 the Teachers' Retirement System of Louisiana (TRSL). State law sets forth timelines for review of applications for disability retirement. As a result, members are encouraged to submit all documents required (including Form 12A, 12C or 12C-P, and all medical records) for the State Medical Disability Board (SMDB) physician's review with this application, but must submit required documents no later than thirty (30) days from the filing of this application.

If approved for TRSL disability retirement benefits by the SMDB, TRSL-covered employment must cease immediately, 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. If you are employed when your disability application is approved, your employment cannot extend beyond the SMDB approval date unless you are exhausting sick and/or annual leave. Once your sick and/or annual leave is exhausted, your employment must cease.

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

Name: Last, first, MI, suffix (Jr., III, etc.)

Daytime telephone ( )

Street / P.O. Box

Evening telephone ( )

City, state, zip

Email address

Your Social Security number - Attach copy of card

Your estimated benefits will not be processed until we receive a copy of your card.

Your date of birth - Attach proof of birthdate

_____ / _____ / _____
mm-dd-yyyy

Check one: (Please attached applicable documents, such as judgments of divorce, death certificates, etc.)

☐ Never married ☐ Married ☐ Divorced* ☐ Re-married* ☐ Legally separated* ☐ Widowed*

Spouse's name: Last, first, MI, suffix (Jr., III, etc.)

Spouse's date of birth - Attach proof

_____ / _____ / _____
mm-dd-yyyy

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.)

1

Name: Last, first, MI, suffix (Jr., III, etc.)

Relationship

Date of birth - Attach proof of birthdate
_____ / _____ / _____
mm/dd/yyyy

Social Security number - Attach copy of card

2

Name: Last, first, MI, suffix (Jr., III, etc.)

Relationship

Date of birth - Attach proof of birthdate
_____ / _____ / _____
mm/dd/yyyy

Social Security number - Attach copy of card

3

Name: Last, first, MI, suffix (Jr., III, etc.)

Relationship

Date of birth - Attach proof of birthdate
_____ / _____ / _____
mm/dd/yyyy

Social Security number - Attach copy of card

4

Name: Last, first, MI, suffix (Jr., III, etc.)

Relationship

Date of birth - Attach proof of birthdate
_____ / _____ / _____
mm/dd/yyyy

Social Security number - Attach copy of card

You may 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

1

Name: Last, first, MI, suffix (Jr., III, etc.)

Date of birth
_____ / _____ / _____
mm/dd/yyyy

Is child with a permanent disability? ☐ Yes ☐ No

Social Security number - Attach copy of card

2

Name: Last, first, MI, suffix (Jr., III, etc.)

Date of birth
_____ / _____ / _____
mm/dd/yyyy

Is child with a permanent disability? ☐ Yes ☐ No

Social Security number - Attach copy of card

3

Name: Last, first, MI, suffix (Jr., III, etc.)

Date of birth
_____ / _____ / _____
mm/dd/yyyy

Is child with a permanent disability? ☐ Yes ☐ No

Social Security number - Attach copy of card

4

Name: Last, first, MI, suffix (Jr., III, etc.)

Date of birth
_____ / _____ / _____
mm/dd/yyyy

Is child with a permanent disability? ☐ Yes ☐ No

Social Security number - Attach copy of card

Complete reverse side

Social Security number

Form 12 (5/20)

Section 5 — Member Description of Condition

1. When did your disability begin? (approximate date is acceptable)

_____ / _____
mm-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 needed, attach additional sheets.):

Name of physician **1**		Name of physician **2**	
Area of specialty	Daytime phone	Area of specialty	Daytime phone
Name of physician **3**		Name of physician **4**	
Area of specialty	Daytime phone	Area of specialty	Daytime phone

6. Mark the major area of specialty of the physician you consult for your disability. 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 witnesses signatures (witnesses may not be named beneficiaries)

I understand that I should receive an acknowledgement letter by mail within approximately one (1) week of TRSL's receipt of my application. If I do not receive this acknowledgement 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)
Signature of witness (Do not print or type) ▶	Signature of witness (Do not print or type) ▶