To apply for disability retirement, you must complete and submit the following forms:

**FORM FR-13, Application for Disability Retirement** - You must provide the Division of Retirement with a properly-signed and completed disability application. Your retirement date is determined by the date the Division receives your disability application. Therefore, you may submit your application prior to submitting the other required forms. Your retirement date will be established as follows:

If you are no longer employed, and your disability application is not received within thirty days of your termination date, your effective retirement date will be the first day of the month following the date we receive your application.

If your disability application is received within thirty days of your termination date, your effective retirement date will be the first day of the month following your termination date.

If you are currently employed in an FRS-covered position, your effective retirement date will be the first day of the month following the date we receive your disability application or the first day of the month following the last month for which salary is reported or creditable service is granted, provided we receive your disability application before such day, and your documented termination date occurs after such day. Your effective retirement date cannot be established until you have officially terminated all FRS-covered employment, and all required documents have been received.

**FORM FR-13a, Statement of Disability by Employer** - This form must be completed and signed by the designated person in your personnel office.

**FORM FR-13b, Physician’s Report** - As proof of disability, Statute 121.091(4) requires two different Florida-licensed physicians who have treated you for your disabling condition to attest to your total and permanent disability.

The Florida Retirement System (FRS) provides two types of disability retirement benefits: in-line-of-duty and regular. You are covered for in-line-of-duty disability retirement from your first day of employment. If your injury or illness arose out of and in the actual performance of your job duties, you may apply for in-line-of-duty disability benefits. Your physicians must attest you are totally and permanently disabled due to an on-the-job injury or illness, and you must provide us with a copy of the Notice of Injury, as filed with Workers’ Compensation. You must have eight years of creditable service to be eligible for regular disability retirement. However, if you terminated employment prior to July 1, 2001, you must have ten years of creditable service to be eligible for regular disability.

To qualify for disability retirement benefits provided for by the FRS, a member must be totally and permanently disabled from performing useful and efficient service as an officer or an employee upon termination from FRS-covered employment, as required by Section 121.091(4), Florida Statutes. Approval for Social Security disability or Workers’ Compensation does not automatically qualify you for an FRS disability retirement benefit. The unavailability of an employment position that you are physically and mentally capable of performing will not be considered as proof of total and permanent disability.

It must be documented that:

1. Your medical condition occurred or became symptomatic during the time you were employed in an employee/employer relationship with your employer;

2. You were totally and permanently disabled at the time you terminated employment; and

3. You have not been employed with any other employer after such termination.

You are responsible for having all forms completed by the proper persons and submitted to the Division of Retirement. Questions concerning the filing of this application should be directed to the Disability Determination Section. The Administrator is authorized by law to make investigations and require additional information, as needed, to reach a decision on your application. Failure to thoroughly complete all items may delay the processing of your application.

You may obtain the forms from your Personnel Office or by contacting the Disability Determination Section at the Division of Retirement by calling at the numbers above or by e-mailing Disability@dms.myflorida.com. You may also download the forms at www.myfrs.com.

Rule 60S-9.001, F.A.C.

Instructions Page 1 of 2
If approved for disability retirement, all of the following are required before your name can be added to the retired payroll:

1. To receive a disability retirement benefit, you must terminate all employment with all FRS and non-FRS employers.

2. Please designate your beneficiary on the attached FORM FR-13, Application for Disability Retirement. All previous beneficiary designations are null and void.

3. A properly completed Option Selection for FRS Members, FORM FRS-110 - You may select an option when you submit your disability application or you may wait until an estimate of benefits is provided. A disability estimate will be provided if you are approved for disability benefits. However, in the event of your death prior to filing an Option Selection Form, by law your option selection will default to Option 1, which does not provide a benefit to your beneficiary. If you select an option, you may change the option selection at any time until a benefit payment has been cashed or deposited. Read carefully the description of each option. You must provide us with your joint annuitant’s date of birth to have Options 3 and 4 calculated.

   Option 1 is a monthly benefit payable for your lifetime. Upon your death, the monthly benefit will stop, and your beneficiary will receive only a refund of any contributions you have paid, which is in excess of the amount you received in benefits.

   Option 1 does not provide a continuing benefit to your beneficiary.

   Option 2 is a reduced monthly benefit payable for your lifetime. If you die prior to receiving 120 monthly payments, your designated beneficiary will receive a monthly benefit in the same amount as you were receiving until the monthly benefits payable to both you and the beneficiary equal 120 monthly payments. If you die after you have received 120 monthly payments, there is no continuing benefit to the beneficiary. Anyone can be named as a beneficiary under Option 2, such as charities, organizations, or your estate or trust.

   Option 3 is a reduced monthly benefit, payable to you while you and your joint annuitant are living. Upon your death, your joint annuitant, if living, will receive a lifetime monthly benefit payment in the same amount as you were receiving.

   Option 4 is an adjusted monthly benefit, payable to you, while you and your joint annuitant are living. Upon the death of either you or your joint annuitant, the monthly benefit, payable to the survivor, is reduced to two-thirds of the monthly benefit received when both were living.

4. A check payable to the Florida Retirement System for any amount you owe, or a written statement that you do not wish to claim the service. Please put your social security number on the face of the check. Or, you can roll over funds from a qualified plan (IRA, deferred compensation, etc.) to pay the amount due, except for upgraded service. The Pre-tax Direct Rollover Form, FORM PRO-1, must be received with the payment. This form can be obtained from our office or the Web page. Otherwise, a written statement must be provided, stating that you do not wish to claim the service.

5. Proof of your birth date. If you select Option 3 or 4, you must also submit birth date verification for your beneficiary. We will accept legible photocopies of one of the following:

   a. Birth Certificate
   b. Delayed birth certificate
   c. Census report more than 30 years old
   d. Life insurance policy more than 30 years old
   e. Letter from the Social Security Administration, stating the date of birth it has established for the payment of benefits
   f. Certificate of Naturalization
   g. In the absence of one of the above, a document from two of the following categories will be required:

      (1) Birth certificate of child, showing age of parent (limit one)
      (2) Baptismal certificate more than 30 years old
      (3) Hospital record of birth
      (4) School record at time of entering grammar school

6. A final certification of your earnings by your employer for the last four months of your employment. Your employer is aware of this requirement.

7. If you claim military service, you must provide the Division with a copy of your FORM DD-214 and a Statement of Military Eligibility, MF-1 or MF-2.

8. Direct Deposit of your benefit is available through the State's Electronic Funds Transfer (EFT) program. An application will be mailed to you after your name has been added to the Retired Payroll. If you are a State employee, currently on EFT, you will automatically continue on EFT unless you cancel your authorization.
Please Print or Type

Applicant Name: ____________________________ Applicant SSN: ____________________________

Street/PO Box Address: ____________________________ Birthdate: ____________________________

City/State/Zip: ____________________________ E-Mail: ____________________________

Phone: ____________________________ / ____________________________

Present (or last) employer: ____________________________

Title of position held: ____________________________

Last Day Actually Worked: ___________ Last Date in Pay Status: ___________ Termination Date: ___________

Type of Disability Benefit You Are Applying For:   ☐ Regular   ☐ In-Line-of-Duty

Describe the illness or injury which has caused your disability and how it prevents you from performing your usual job duties.

__________________________________________________________________________________________________________________________________________________

1. Educational Background--Circle the highest grade level you have completed:

   Grammar School: 12345678  High School: 9101112  College: 1234  Graduate School: 1234  Other: __________

2. Work History--List your two previous jobs prior to your current employment:

   Job: ___________________________________ From: ___________ / ___________ To: ___________ / ___________

   Job: ___________________________________ From: ___________ / ___________ To: ___________ / ___________

3. If you have any other physical impairments, please describe them and the length of time they have existed:

   ____________________________________________________________________________________________

4. If you have made any Workers’ Compensation claims, please list date(s) of accident(s) and employer(s).

   Date: ____________________________ Employer: ____________________________

   Date: ____________________________ Employer: ____________________________

List the names, addresses and phone numbers of the physicians currently or most recently treating you:

A. Name of Physician & Address: ____________________________ Phone: ___________ / ___________

   ________________________________________________

   ________________________________________________

B. Name of Physician & Address: ____________________________ Phone: ___________ / ___________

   ________________________________________________

   ________________________________________________

Rule 60S-9.001, F.A.C.
Page 1 of 2
Florida Retirement System Pension Plan
Application for Disability Retirement

Applicant Name: ___________________________ Applicant SSN: ___________________________

Authorization for Release of Information:
I hereby apply for disability retirement benefits. This application is being made because of a disability which incapacitates me for the performance of any useful work and I affirm that all information and statements are true and correct to the best of my knowledge.

I hereby authorize any physician, hospital, or clinic to give full and complete information concerning me or my medical condition including any prior history to the Division of Retirement, State of Florida, or its authorized representative.

In addition to the above general medical release, I hereby specifically authorize the release of any records which may exist concerning me, including but not limited to employment or personnel records with previous employers, including records with a School Board, Community College, or Public School System, or records with other Retirement Systems, the Veteran’s Administration, Social Security Administration, Workers’ Compensation records, or any other records which a personal release signed by me may be required. Please cooperate with the bearer of this release. This Authorization for Release of Information is valid throughout the duration of my claim.

Date: ___________________________ Applicant Signature: ___________________________

Option Selection:
You may complete an Option Selection for FRS Members, FORM FRS-11o, and submit it along with your application to select an option; or you may wait until an estimate of benefits is provided. A Disability estimate will be provided if you are approved for disability benefits. However, in the event of your death prior to filing an Option Selection form, your option selection will default to Option 1, which does not provide a benefit to your beneficiary. If you select an option, you may change the option selection at any time until a benefit payment has been cashed or deposited. You must provide us with your joint annuitant’s date of birth to have Options 3 and 4 calculated.

Beneficiary Designation:
All previous beneficiary designations are null and void. To designate more than one primary beneficiary, attach a Beneficiary Designation Form, FST-12:

Primary ___________________________________________ Primary SSN __________ / __________ / __________

Relationship ___________________________ Primary Birthdate __________ / __________ / __________

Contingent ___________________________________________ Contingent SSN __________ / __________ / __________

Relationship ___________________________ Contingent Birthdate __________ / __________ / __________

I understand I must terminate all employment with FRS employers to receive a retirement benefit under Chapter 121, Florida Statutes. I also understand that I cannot add additional service, change options, or change my type of retirement (Regular, Disability and Early) once my retirement becomes final. My retirement becomes final when any benefit payment is cashed or deposited. I understand, as a disabled retiree, I cannot work in any capacity and receive a disability benefit. I acknowledge that I have read and understand the instructions on Pages 1 and 2.

Applicant Signature (Sign in presence of Notary Public): ___________________________________________

Notary:
State of ______________. County of ______________ The above named person who has sworn to and subscribed before me this __________ day of ______________, 20__ and who is personally known __________ or produced ______________ identification.

Signature of Notary Public

Rule 60S-9 001, F.A.C.
Page 2 of 2
Florida Retirement System
Physician’s Report

PO Box 9000
Tallahassee, FL 32315-9000
(850) 488-2968
Toll Free: 1-877-738-3725

Applicant Name ____________________________  Applicant SSN _______________________

Position Title ______________________________  Employer __________________________

Check One:

Regular Disability: _____ Florida Statutes, Chapter 121.091(4)(b), Total and permanent disability. “A member shall be considered totally and permanently disabled if, in the opinion of the administrator, he is prevented, by reason of a medically determinable physical or mental impairment, from rendering useful and efficient service as an officer or employee.”

In-Line-Of-Duty Disability: _____ Florida Statutes, Chapter 121.021(13) “Disability in line of duty means an injury or illness arising out of and in the actual performance of duty required by a member's employment during regularly scheduled working hours or irregular working hours as required by the employer . . .”

Authorization for release of medical information

I authorize my physician to release any information recorded on the examination report and any other pertinent facts and documents concerning my condition to the Florida Retirement System.

__________________________________________  ____________________________
Applicant Signature                        Date

Physician’s Statement

The patient is responsible for completion of this form without expense to the State of Florida. Please provide any additional information and copies of your office notes, if you feel they are pertinent to an understanding of this patient’s condition. However, office notes CANNOT be submitted in lieu of properly completing page two of this form.

License Number ____________________________  Physician’s Name (Please print)

Issued By Florida Board of Medical Examiners

Specialty ________________________________  Address __________________________

Fax ____________________________  Phone __________________________

Rule 60S-9.001, F.A.C.
Page 1 of 2
Florida Retirement System
Physician's Report

Applicant Name: ___________________________________________ Applicant SSN: _______________________________________

1. Diagnosis:
   a) When did you first treat this patient? Date: ___________________________
   b) Date of most recent examination: _________________________________
   c) Primary disabling condition: _________________________________
   d) Secondary condition(s): _______________________________________
   e) What restrictions have you placed on the patient's activities? ____________

2. Prognosis:
   a) Has the patient's condition stabilized? Yes ___ No ___
   b) Has the patient reached maximum medical improvement? Yes ___ No ___
   c) If so, when did the patient reach maximum medical improvement? Date __________
   d) Is the patient a candidate for vocational rehabilitation? Yes ___ No ___
   e) Additional comments: ___________________________________________

3. Physical and/or Mental Impairment:
   ______ No limitation of functional capacity; may return to work.
   ______ Slight limitation of functional capacity; capable of light work.
   ______ Moderate limitation of functional capacity; capable of sedentary work.
   ______ Cannot perform present work, but capable of performing another line of work.
   ______ Temporary limitation of functional capacity; temporarily incapable of any kind of work; temporarily disabled from gainful employment.
   ______ Severe limitation of functional capacity; permanently incapable of any kind of work; totally and permanently disabled from gainful employment.

4. In-Line-Of-Duty: (Complete only if "in-line-of-duty" disability retirement was checked on opposite page and injury arose out of the performance of duty. All four questions must be answered.)
   a) Is the patient's primary disability due to an on-the-job injury or illness? __________________________
   b) If so, what was the date of the injury? __________________________________________
   c) How do you relate the primary disability to the on-the-job injury? __________________________
   d) Is there any cause other than the on-the-job injury contributing to the patient's disability? Please explain: __________________________

Additional Comments: __________________________________________

__________________________________________ _____________
Physician's Signature Date

____________________________________________
Physician's Name (Please Print)

Rule 60S-9.001, F.A.C.
Page 2 of 2
Florida Retirement System
Physician's Report

Applicant Name ____________________________  Applicant SSN ____________________________
Position Title ______________________________  Employer ________________________________

Check One:

Regular Disability: ☐ Florida Statutes, Chapter 121.091(4)(b), Total and permanent disability. "A member shall be considered totally and permanently disabled if, in the opinion of the administrator, he is prevented, by reason of a medically determinable physical or mental impairment, from rendering useful and efficient service as an officer or employee."

In-Line-Of-Duty Disability: ☐ Florida Statutes, Chapter 121.021(13) "Disability in line of duty means an injury or illness arising out of and in the actual performance of duty required by a member's employment during regularly scheduled working hours or irregular working hours as required by the employer . . ."

Authorization for release of medical information

I authorize my physician to release any information recorded on the examination report and any other pertinent facts and documents concerning my condition to the Florida Retirement System.

________________________________________  ____________________________
Applicant Signature  Date

Physician's Statement

The patient is responsible for completion of this form without expense to the State of Florida. Please provide any additional information and copies of your office notes, if you feel they are pertinent to an understanding of this patient's condition. However, office notes CANNOT be submitted in lieu of properly completing page two of this form.

License Number ____________________________  ____________________________
Issued By Florida Board of Medical Examiners  Physician's Name (Please print)

Specialty ____________________________  Address ____________________________
Fax ____________________________  ____________________________
Phone ____________________________  ____________________________
Florida Retirement System
Physician's Report

Applicant Name: ___________________________  Applicant SSN: _______________________

1. **Diagnosis:**
   a) When did you first treat this patient? Date: _____________________________
   b) Date of most recent examination: _____________________________
   c) Primary disabling condition: ____________________________________________
   d) Secondary condition(s): ________________________________________________
   e) What restrictions have you placed on the patient's activities? ________

2. **Prognosis:**
   a) Has the patient's condition stabilized? Yes ___ No ___
   b) Has the patient reached maximum medical improvement? Yes ___ No ___
   c) If so, when did the patient reach maximum medical improvement? Date: __________
   d) Is the patient a candidate for vocational rehabilitation? Yes ___ No ___
   e) Additional comments: ___________________________________________________

3. **Physical and/or Mental Impairment:**
   ___________ No limitation of functional capacity; may return to work.
   ___________ Slight limitation of functional capacity; capable of light work.
   ___________ Moderate limitation of functional capacity; capable of sedentary work.
   ___________ Cannot perform present work, but capable of performing another line of work.
   ___________ Temporary limitation of functional capacity; temporarily incapable of any kind of work; temporarily disabled from gainful employment.
   ___________ Severe limitation of functional capacity; permanently incapable of any kind of work; totally and permanently disabled from gainful employment.

4. **In-Line-Of-Duty:** (Complete only if "in-line-of-duty" disability retirement was checked on opposite page and injury arose out of the performance of duty. All four questions must be answered.)
   a) Is the patient's primary disability due to an on-the-job injury or illness? ___________
   b) If so, what was the date of the injury? ____________________________
   c) How do you relate the primary disability to the on-the-job injury? __________________________
   d) Is there any cause other than the on-the-job injury contributing to the patient's disability? Please explain: ___________

Additional Comments: ____________________________________________________________

______________________________________________________________________________

Physician's Signature ___________________________ Date ___________________________

______________________________________________________________________________

Physician's Name (Please Print) ___________________________________________________
Florida Retirement System Pension Plan
Option Selection for Members

P O BOX 9000
TALLAHASSEE FL 32315-9000
(850) 488-6491 Toll Free (888) 738-2252

Member Name ___________________________________________________ Member SSN ________________________________

A member must select one of the following retirement options prior to receipt of their first monthly retirement benefit.

I select:

_______ Option 1: A monthly benefit payable for my lifetime. Upon my death the monthly benefit will stop and my
beneficiary will receive only a refund of any contributions I have paid which are in excess of the
amount I have received in benefits. This option does not provide a continuing benefit to my
beneficiary.

_______ Option 2: A reduced monthly benefit payable for my lifetime. If I die within a period of ten years after my
retirement date, my designated beneficiary will receive a monthly benefit in the same amount as I
was receiving for the balance of the 10-year period. No further benefits are then payable.

_______ Option 3: A reduced monthly benefit payable for my lifetime. Upon my death, my joint annuitant, if living, will
receive a lifetime monthly benefit payment in the same amount as I was receiving. (Exception: The
benefit paid to a joint annuitant under age 25, who is not your spouse, will be your option one benefit
amount. The benefit will stop when your joint annuitant reaches age 25, unless disabled and
incapable of self-support, in which case the benefit will continue for the duration of the disability.) No
further benefits are payable after both my joint annuitant and I are deceased. The social security number of my joint annuitant is ________________________ .

_______ Option 4: An adjusted monthly benefit payable to me while both my joint annuitant and I are living. Upon the
death of either my joint annuitant or me, the monthly benefit payable to the survivor is reduced to
two-thirds of the monthly benefit received when both were living. (Exception: The benefit paid to a
joint annuitant under age 25, who is not your spouse, will be your option one benefit amount. The
benefit will stop when your joint annuitant reaches age 25, unless disabled and incapable of
self-support, in which case the benefit will continue for the duration of the disability.) No further
benefits are payable after both my joint annuitant and I are deceased. The social security number of my joint annuitant is ________________________ .

PLEASE COMPLETE FORM SA-1

I understand I must terminate all employment with FRS employers to receive a retirement benefit under Chapter 121,
Florida Statutes. I also understand that I cannot add service, change options or change my type of retirement (Regular,
Disability and Early) once my retirement becomes final. My retirement becomes final when any benefit payment is
cashed, deposited or when my Deferred Retirement Option Program(DROP) participation begins.

Member Signature (sign in the presence of a Notary) __________________________________________________________

Notary: State of Florida, County of _________________________ The above named person has sworn to and

subscribed before me this ___________ day of _______________ 20 ______ and is personally known ________ or

produced ________________________________ as identification.

Signature of Notary Public - State of Florida ____________________________ Print, Type or Stamp Commissioned Name of Notary Public

Rule 6OS 9.001, F A C.
Page 1 of 1
Florida Retirement System Pension Plan
Spousal Acknowledgment Form
PO BOX 9000
Tallahassee FL 32315-9000
(850) 488-6491 Toll Free (888) 738-2252

Member Name: ___________________________ Member SSN: _______________________

CHECK ONE OF THE FOLLOWING:

MARRIED: _____ YES _____ NO
IF YES AND YOU SELECTED OPTION 1 OR 2,
YOUR SPOUSE MUST ALSO COMPLETE BOX 2.

Notarized Signature of Member: ___________________________

Notary: State of Florida, County of ___________________________
The above named person has sworn to and
subscribed before me this ______ day of ______ 20__ and is personally known _______ or
produced ___________________________ as identification.

Signature of Notary Public - State of Florida
Print, Type or Stamp Commissioned Name of Notary Public

SPOUSAL ACKNOWLEDGMENT: I, ___________________________ being the spouse of the
above named member, acknowledge that the member has selected either Option 1 or 2.

Notarized Signature of Spouse: ___________________________

Notary: State of Florida, County of ___________________________
The above named person has sworn to and
subscribed before me this ______ day of ______ 20__ and is personally known _______ or
produced ___________________________ as identification.

Signature of Notary Public - State of Florida
Print, Type or Stamp Commissioned Name of Notary Public

The following is an explanation of all four Florida Retirement System Options:

Option 1: A monthly benefit payable for my lifetime. Upon my death, the monthly benefit will stop and my beneficiary will receive only a refund of any contributions I have paid which are in excess of the amount I have received in benefits. This option does not provide a continuing benefit to my beneficiary.

Option 2: A reduced monthly benefit payable for my lifetime. If I die within a period of ten years after my retirement date, my designated beneficiary will receive a monthly benefit in the same amount as I was receiving for the balance of the 10-year period. No further benefits are then payable.

Option 3: A reduced monthly benefit payable for my lifetime. Upon my death, my joint annuitant, if living, will receive a lifetime monthly benefit payable in the same amount as I was receiving. (Exception: The benefit paid to a joint annuitant under age 25, who is not your spouse, will be your option one benefit amount. The benefit will stop when your joint annuitant reaches age 25, unless disabled and incapable of self-support, in which case the benefit will continue for the duration of the disability.) No further benefits are payable after both my joint annuitant and I are deceased.

Option 4: An adjusted monthly benefit payable to me while both my joint annuitant and I are living. Upon the death of either my joint annuitant or me, the monthly benefit payable to the survivor is reduced to two-thirds of the monthly benefit received when both were living. (Exception: The benefit paid to the joint annuitant under age 25, who is not your spouse, will be your option one benefit amount. The benefit will stop when your joint annuitant reaches age 25, unless disabled and incapable of self-support, in which case the benefit will continue for the duration of the disability.) No further benefits are payable after both my joint annuitant and I are deceased.

Rule 605-3.001, F.A.C.
Page 1 of 1