COLORADO PERA

Disability Program Application

Colorado Public Employees' Retirement Association
PO Box 5800, Denver, Colorado 80217-5800
1-800-759-PERA (7372) • Fax: 303-863-3727 • www.copera.org

Important: Colorado PERA must receive this form as soon as your medical condition prevents you from engaging in your regular duties, but no later than 90 days after you terminate employment. Be sure to complete the *Authorization to Obtain Information* on the reverse. **A signature is required on both sides of this form.**

Member Information

Name _____ SSN _____

Address _____
Street City State ZIP Code

Work Phone _____ Home Phone _____

Birthdate _____ Sex: ❑ Male ❑ Female
Month/Day/Year

If Married _____
Name of Spouse Birthdate SSN

Email Address _____

Sign up for electronic delivery of PERA information? ❑ Yes ❑ No

Employment Information

See page 3 for the definition of your date of termination from employment

Employer Name _____ Telephone _____

Address _____
Street City State ZIP Code

Have you terminated employment? ❑ Yes ❑ No Date of termination _____
Month/Day/Year

Your Job Title _____ Date of your last full day at work _____
Month/Day/Year

Date you became unable to work as a result of your disability _____
Month/Day/Year

Is your disability work-related? ❑ Yes ❑ No Have you filed a workers' compensation claim? ❑ Yes ❑ No

Are you now working or have you worked at your job or any other job since the date of your disability? ❑ Yes ❑ No

Date returned to work _____
Month/Day/Year

Sickness or Injury

Please attach a separate sheet if necessary

List any physical or mental sickness or injury that causes or contributes to your inability to work at your job.

Sickness or injury _____ Date first noticed _____
Month/Day/Year

Please describe your symptoms: _____

_____

_____

Have you ever had a similar condition before? ❑ Yes ❑ No Date _____
Month/Day/Year

Attending Physician(s)

Please attach a separate sheet if necessary

List all physicians consulted for your sickness or injury.

1. Physician's Name _____ Telephone _____

Address _____
Street City State ZIP Code

Fax Number _____ Date first consulted for your sickness or injury _____
Month/Day/Year

Date last consulted _____
Month/Day/Year

2. Physician's Name _____ Telephone _____

Address _____
Street City State ZIP Code

Fax Number _____ Date first consulted for your sickness or injury _____
Month/Day/Year

Date last consulted _____
Month/Day/Year

Signature Certification

Any person who knowingly and with intent to injure, defraud, or deceive an insurance company or other person files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act, which may be subject to civil and/or criminal penalties. Such actions may be deemed a felony, and imprisonment and/or substantial fines may be imposed.

Sign Here → **Member Signature** _____ **Date** _____

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Authorization Information

I authorize these persons/organizations having any records or knowledge of me or my health:

- » Any physician, medical practitioner, or health care provider.
- » Any hospital, clinic, pharmacy, or other medical or medically-related facility or association.
- » Any insurance company.
- » Any employer or plan administrator.
- » Any organization or entity administering a benefit program.
- » Any educational, vocational, or rehabilitational organization or program.
- » Any consumer reporting agency, financial institution, accountant, or tax preparer.
- » Any government agency (for example, Social Security Administration, public retirement system, etc.).

To provide the following:

- » Charts, notes, X-rays, operative reports, lab and medication records, and all other medical information about me, including medical history, diagnosis, testing, and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS), or other related syndromes or complexes.
- » Any communicable disease or disorder.
- » Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.
- » Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.
- » Any non-medical information requested about me, including such things as: education, employment history, job descriptions, job duties, earnings or finances, or eligibility for other benefits (for example, Social Security Administration, public retirement systems, claim status, benefit amounts, and effective dates, etc.).

To Unum:

I understand that Unum will use the information to determine my eligibility or entitlements under the PERA Disability Program.

I understand and agree that this *Authorization* shall remain in force throughout the duration of my claim for payments with Unum. I understand that I have the right to revoke this *Authorization* at any time by sending a written statement to Unum, and that revocation of the *Authorization,* or the failure to sign the *Authorization,* may impair Unum's ability to evaluate or process my application. Revocation of the *Authorization* may be a basis for denying my claim for payments.

I understand that in the course of conducting its business, Unum may disclose to other parties information it has about me. Unum may release this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for Unum in connection with my application.

I understand that Unum complies with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to Unum pursuant to this *Authorization* may be subject to redisclosure with my *Authorization* or as otherwise permitted or required by law. (Disability coverage is not subject to the Privacy Rules of the Health Insurance Portability and Accountability Act (HIPAA) and therefore the release of information to Unum is not protected under the Act.)

Signature Certification

I acknowledge that I have read the "Authorization Information" section above. A photocopy or facsimile of this *Authorization* is as valid as the original and will be provided to me upon request.

Member's Name _____ SSN _____
Please Print

Sign Here ➔ Signature of Member/Guardian/Representative _____ Date _____
Month/Day/Year

Unum Authorization

Authorization for Unum to release information to PERA.

This "Unum Authorization" to release information is optional and will not impair your eligibility to obtain PERA disability payments.

I authorize Unum to release information contained in my file, including any of the information identified above, to PERA for the purpose of conducting performance audits of Unum. **I acknowledge that I have read the *Authorization*** and I understand and agree that this *Authorization* shall remain in force for one year from the date of signature. A photocopy of this *Authorization* is as valid as the original.

Member's Name _____
Please Print

Sign Here ➔ *(Optional)* Signature of Member/Guardian/Representative _____ Date _____
Month/Day/Year

8/10-disapp (REV 7-19)