mcera
Marin County Employees' Retirement Association
One McInnis Parkway, First Floor, San Rafael, CA 94903 • Phone: (415) 473-6147 • Fax: (415) 473-3612 • www.mcera.org

DISABILITY RETIREMENT APPLICATION PACKET CHECKLIST

THIS PACKET CONTAINS THE FOLLOWING DOCUMENTS:

- ☒ Disability Retirement Information sheet
- ☒ Disability Retirement Process flowchart
- ☒ Disability Retirement Application form
- ☒ Authorization for Release of Medical, Psychiatric, and Employment Information
- ☒ Kaiser Authorization for Release of Patient Information

YOU MAY USE THE CHECKLIST BELOW AS A GUIDE TO ENSURE THAT YOU RETURN A COMPLETE DISABILITY RETIREMENT APPLICATION PACKET TO MCERA:
[NOTE: Applicant must submit original plus three (3) copies of application and all supporting documentation.]

- ☐ Signed Disability Retirement Information sheet
- ☐ Completed Disability Retirement Application form
- ☐ Completed Release of Medical, Psychiatric, and Employment Information form
- ☐ Completed Kaiser Authorization for Release of Patient Information (as applicable)
- ☐ Supporting documentation

SUBMIT COMPLETED DISABILITY RETIREMENT APPLICATION PACKET TO:

MCERA
One McInnis Parkway, Suite 100
San Rafael, CA 94903
(415) 473-6147

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DISABILITY RETIREMENT INFORMATION

(PLEASE PRINT)

APPLICANT INFORMATION:

NAME _____ SOCIAL SECURITY NUMBER _____

If your disability is permanent, you may be eligible for a disability retirement. For purposes of the Retirement Plan, a disability is defined as a mental or physical condition that renders you permanently incapable of performing a substantial portion of the duties of your job.

SERVICE-CONNECTED VS. NON SERVICE-CONNECTED

The Retirement Plan provides for two types of disability retirement: non-service connected and service-connected.

To be eligible for a non-service connected disability retirement, you must be credited with at least 5 years of service. Documentation establishing that you are permanently disabled and that the disability prevents you from performing a substantial portion of your duties should be submitted along with your application.

Regardless of your length of service, you may be eligible for a service-connected disability if you can prove a real and measurable relationship between your disability and your employment. Documentation establishing that you are permanently disabled and that the disability prevents you from performing a substantial portion of your duties, and documentation proving that there is substantial evidence of a real and measurable relationship between your disability and your employment must be submitted along with your application.

The Marin County Employees' Retirement Association is governed by the provisions of the Association's Bylaws and the California Government Code (Chapter 2, Part 3, Division 4). The Retirement Board is responsible for determining the validity of your claim. You are entitled to notice and a hearing on the issues and have the right, at your expense, to representation by an attorney of your choice.

APPLICATION

The application must be submitted while you are in service or within four months after your discontinuance of service. You may submit an application at a later date if you can demonstrate that you were permanently and continuously disabled from the time of separation. Service is defined as uninterrupted employment for that period of time for which retirement contributions are deducted from earnable compensation.

The burden of proof is upon the applicant to establish proof of the disability; that the disability resulted in permanent incapacity for performance of duty; and where applicable, that the incapacity resulted from injury or disease arising out of and in the course of your employment.

[***Continued on next page***]

[***Continued from previous page***]

Prior to the Retirement Board considering your application, you should submit documentation which supports the existence of your disability, your incapacity, that your condition is "permanent and stationary," meaning that you are unlikely to benefit from further medical treatment, and where applicable, the fact that your incapacity is employment related.

We require an original plus three (3) copies of all supporting documentation (including the application) that you wish to submit in support of your application.

PROCEDURE

Please refer to the Disability Retirement Process flowchart for a detailed description of the procedures.

If approved, your disability retirement will become effective on the date of your application (the day that the application is received in the Retirement Office) or the day following the last day for which you received compensation, whichever is later.

This document is not intended to be an exhaustive analysis of all procedures, benefits and liabilities which may accrue with respect to your application for disability retirement. If you have questions not answered here, you should contact the Retirement Office or your attorney. Additional information may be found in Part X of the MCERA Bylaws and Regulations (available online at http://www.mcera.org).

Please sign below and return this form along with your application and supporting documents to the Retirement Office.

I have read and understand the information contained above.

_____ _____

APPLICANT SIGNATURE DATE

MARIN COUNTY EMPLOYEES' RETIREMENT ASSOCIATION

Disability Retirement Process

This diagram shows the step-by-step process from original application to final decision.

1 ***INJURY OR ILLNESS:*** Member has been injured, becomes ill, or is placed on disability status. Member can apply for disability retirement while on Workers' Compensation or 4850 benefits.

2 ***WRITTEN DIAGNOSIS:*** Obtain written diagnosis of your injury or illness, prognosis that your disability is permanent, and the causation from your treating physician on Doctor's stationery.

3 ***APPLY FOR DISABILITY:*** Contact the Retirement Office to inform us of your injury or illness. Complete an application for disability retirement. The application must be accompanied by a Doctor's diagnosis, prognosis and all supporting documentation.

4 ***DISABILITY RETIREMENT COUNSELING:*** Retirement staff will discuss Service vs. Non-Service Connected Disability and eligibility requirements for Service Retirement. Retirement staff will check for eligibility to receive a service retirement or Advance Disability Retirement Payments (ADRP) (available to those who are eligible for paid 4850 time) pending the outcome of the disability retirement application.
NOTE: The decision to begin receiving a service retirement will prevent you from returning to work while continuing to receive a retirement benefit should the Retirement Board deny your application.

5 ***APPLICATION REVIEWED:*** Your application, physician's medical evidence and supporting documentation are reviewed for completeness prior to being accepted. Once complete, your application is accepted and staff will begin processing the application.

6 ***LETTER TO EMPLOYER:*** An initial step in processing your application is to request information from your employer regarding your injury and whether reasonable accommodation has been attempted.

7 ***MEDICAL RECORDS COLLECTION:*** Documentation is obtained from Workers' Compensation, all treating physicians and personnel files. All medical records obtained by this office are confidential.

8 ***INITIAL MEDICAL REVIEW AND EXAMINATION:*** Retirement staff and MCERA medical consultant review all medical documentation. Following review, an independent medical examination is scheduled.

9 ***INDEPENDENT MEDICAL EXAMINATION:*** Applicant attends medical examination with a Board-approved physician. Physician prepares report following examination and sends to MCERA.

10 ***MEDICAL CONSULTANT REVIEW:*** MCERA medical consultant and staff review physician's report. Consultant prepares summary report and recommendation for Retirement Board.

11 ***STAFF RECOMMENDATION:*** Retirement staff prepares a Recommendation and Findings of Fact, if appropriate. The matter is Presented to the Retirement Board.

12 ***THE BOARD MAY:***

1. *Grant Your Application*: If medical evidence/ documentation supports your application the Retirement Board may grant your application.
2. *Remand to Staff* for additional information.
3. *Deny Your Application*: If medical evidence/ documentation does not support your application or if there is conflicting medical evidence, the Retirement Board may deny your application. If your application is denied based on disputed factual issues, you may appeal the Board's decision by providing a written request for a hearing to the Retirement Administrator, which must be received by MCERA no later than 60 days after MCERA mails you notification of the denial. The Board may, in its sole discretion, waive this deadline upon a showing of good cause.
Decision: The applicant/attorney (if represented) is notified that the application is denied within 10 days of the decision by the Retirement Board.

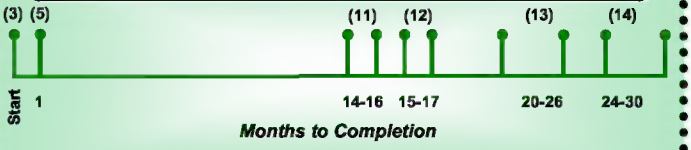
13 ***DISABILITY HEARING:***

1. *Prepare for Hearing*: Applicant/attorney may request hearing before an Administrative Law Judge (ALJ). MCERA strongly recommends that you retain legal counsel to prepare your case. County Counsel represents MCERA during the hearing.
2. *Selection of Hearing Officer:* MCERA counsel will work with applicant's attorney to schedule the hearing with the ALJ.
3. *Notice of Hearing*: MCERA counsel sets the date and time of the hearing and notifies attorneys, court reporter, applicant and Hearing Officer of time and location of the hearing.
4. *Hearing Held*: Member presents his/her case to the ALJ. MCERA appears through County Counsel. The ALJ prepares recommendation to grant or deny the application within 30 days of hearing.

14 ***BOARD DECISION AFTER HEARING:***

1. *The ALJ's Recommendation*: ALJ prepares recommendation to be sent to the Board. The Board has the option to adopt the recommendation, require a transcript or summary of all evidence received by the referee and take action based on such evidence, send the recommendation back to the ALJ for further proceedings, or to rehear the matter themselves.
2. *Objections/Responses*: Member has 10 days from the notification date to file objections with the Retirement Board.
3. *Notice of Decision*: Applicant/attorney is sent a notice of decision.
4. *Appeal:* Member may also file an appeal in Superior Court within 90 days of the date notified of the decision.

TIMELINE ESTIMATE FOR DISABILITY RETIREMENT



For more information, call MCERA at:
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DISABILITY RETIREMENT APPLICATION

(PLEASE PRINT)

I have become permanently incapacitated from the performance of my duties and, accordingly, I hereby apply for:

☐ Service connected disability retirement.

☐ Non-service connected disability retirement.

APPLICANT INFORMATION

LAST NAME _____ SOCIAL SECURITY NUMBER _____

FIRST NAME _____ HOME PHONE _____

STREET ADDRESS _____ WORK PHONE _____

CITY / STATE / ZIP _____ CELL PHONE _____

Sex: ☐ Male ☐ Female AGE _____ BIRTHDATE _____

EMPLOYMENT INFORMATION

EMPLOYER _____ LAST POSITION HELD _____

DEPARTMENT _____ DATE LAST WORKED _____

SUPERVISOR _____ YEARS OF SERVICE _____

CURRENT EMPLOYMENT STATUS

(CHECK ALL THAT APPLY)

☐ Working _____ hours per week
☐ Sick leave with compensation
☐ Sick leave without compensation
☐ Retired. Date: _____
☐ Other: _____
☐ Receiving 4850 time
☐ Resigned or terminated from service
☐ Working on a modified schedule or with accommodation

1. Describe specifically the injury or illness that you claim is causing you to be permanently disabled from performing your duties.

_____

_____

_____

2. How and where did the injury or illness occur? Please answer completely.

_____

_____

_____

_____

_____

3. On what date were you injured, or first noticed that you were ill? _____

4. If your disability is the result of a job-related injury, list all of the witnesses who observed the injury. Give names, work locations, telephone numbers and addresses of such persons and state your relationship to each. Please use an additional sheet if necessary.

(1)WITNESS' NAME	(1)RELATIONSHIP TO APPLICANT
(1)WITNESS' WORK LOCATION	(1)WITNESS' PHONE
(1)WITNESS' STREET ADDRESS	(1)WITNESS' CITY / STATE / ZIP
(2)WITNESS' NAME	(2)RELATIONSHIP TO APPLICANT
(2)WITNESS' WORK LOCATION	(2)WITNESS' PHONE
(2)WITNESS' STREET ADDRESS	(2)WITNESS' CITY / STATE / ZIP
(3)WITNESS' NAME	(3)RELATIONSHIP TO APPLICANT
(3)WITNESS' WORK LOCATION	(3)WITNESS' PHONE
(3)WITNESS' STREET ADDRESS	(3)WITNESS' CITY / STATE / ZIP
(4)WITNESS' NAME	(4)RELATIONSHIP TO APPLICANT
(4)WITNESS' WORK LOCATION	(4)WITNESS' PHONE
(4)WITNESS' STREET ADDRESS	(4)WITNESS' CITY / STATE / ZIP

5. Please attach a copy of the job description for the position that you currently hold. County of Marin employee job descriptions may be located on the County's Human Resources website. If you need assistance, please contact the Retirement Office. Please answer the following questions.

   a. Is the job description accurate? ☐ Yes ☐ No

   b. If you answered "No" to question 5.a., please list the duties you performed which you feel are omitted from the description. Also, list those duties included in the description which you did not perform on a regular and routine basis.

   _____

   _____

   _____

   c. Please list the <u>essential</u> functions of your position and whether you are able to perform them.

   _____ ☐ Yes ☐ No

   _____ ☐ Yes ☐ No

   _____ ☐ Yes ☐ No

   _____ ☐ Yes ☐ No

6. State in detail the duties you cannot now perform due to your injury or illness.

   _____

   _____

   _____

   _____

7. Have you also filed a Workers' Compensation claim? ☐ Yes ☐ No

   a. If you answered "Yes" to question 7, please fill in the fields below.
   Claim number: _____ Date claim submitted: _____
   Status of the claim: ☐ Pending ☐ Approved ☐ Denied

   b. If you answered "No" to question 7, please explain why a claim was not submitted.

   _____

   _____

   _____

8. Have you ever received treatment for a SIMILAR injury or illness? ☐ Yes ☐ No

a. If you answered "Yes" to question 8, please provide names, addresses, telephone numbers, and dates of treatment for all physicians or health care providers. Please attach a separate sheet if necessary.

(1)MEDICAL PROVIDER NAME

(1)MEDICAL PROVIDER ADDRESS

(1)MEDICAL PROVIDER TELEPHONE NUMBER(S)

(1)DATES OF TREATMENT

(2)MEDICAL PROVIDER NAME

(2)MEDICAL PROVIDER ADDRESS

(2)MEDICAL PROVIDER TELEPHONE NUMBER(S)

(2)DATES OF TREATMENT

(3)MEDICAL PROVIDER NAME

(3)MEDICAL PROVIDER ADDRESS

(3)MEDICAL PROVIDER TELEPHONE NUMBER(S)

(3)DATES OF TREATMENT

(4)MEDICAL PROVIDER NAME

(4)MEDICAL PROVIDER ADDRESS

(4)MEDICAL PROVIDER TELEPHONE NUMBER(S)

(4)DATES OF TREATMENT

b. Did any of the above consultations result in a Workers' Compensation claim being filed?

☐ Yes ☐ No

If you answered "Yes" to question 8.b., please indicate which ones.

9. Are you presently employed, full-time, part-time, or otherwise, or do you do volunteer work for anyone other than the employer under which you incurred your injury or illness?

☐ Yes ☐ No

a. If you answered "Yes" to question 9, please list the employer or volunteer work organization, address, telephone number, and your job duties.

(1)EMPLOYER/VOLUNTEER ORGANIZATION _____ (1)SUPERVISOR _____

(1)STREET ADDRESS _____ (1)CITY / STATE / ZIP _____

(1)TELEPHONE _____ ☐ Full-time ☐ Part-time ☐ Other: _____

(1)JOB DUTIES _____

(2)EMPLOYER/VOLUNTEER ORGANIZATION _____ (2)SUPERVISOR _____

(2)STREET ADDRESS _____ (2)CITY / STATE / ZIP _____

(2)TELEPHONE _____ ☐ Full-time ☐ Part-time ☐ Other: _____

(2)JOB DUTIES _____

(3)EMPLOYER/VOLUNTEER ORGANIZATION _____ (3)SUPERVISOR _____

(3)STREET ADDRESS _____ (3)CITY / STATE / ZIP _____

(3)TELEPHONE _____ ☐ Full-time ☐ Part-time ☐ Other: _____

(3)JOB DUTIES _____

10. List <u>all</u> employers (including other County departments or agencies), dates of employment, and name of supervisor for whom you have worked in the last ten (10) years. Please attach a separate sheet if necessary.

(1)EMPLOYER/DEPARTMENT _____ (1)DATES OF EMPLOYMENT _____

(1)EMPLOYER STREET ADDRESS _____ (1)EMPLOYER CITY / STATE / ZIP _____

(1)SUPERVISOR NAME _____ (1)SUPERVISOR TELEPHONE _____

(2)EMPLOYER/DEPARTMENT _____ (2)DATES OF EMPLOYMENT _____

(2)EMPLOYER STREET ADDRESS _____ (2)EMPLOYER CITY / STATE / ZIP _____

(2)SUPERVISOR NAME _____ (2)SUPERVISOR TELEPHONE _____

(3)EMPLOYER/DEPARTMENT

(3)DATES OF EMPLOYMENT

(3)EMPLOYER STREET ADDRESS

(3)EMPLOYER CITY / STATE / ZIP

(3)SUPERVISOR NAME

(3)SUPERVISOR TELEPHONE

11. Is it possible that your injury or illness was caused or related, in whole or in part, to any injury, problems or incident involving any third party, other than your most recent employer?

☐ Yes ☐ No

12. Have you filed, or are you considering filing, any claim or lawsuit against any third party or its insurance company for any injury, disability, or loss of past or future income or earning capacity?

☐ Yes ☐ No

13. If applicable, include the name, address, and telephone number of the third party(ies) and/or insurance company(ies). Please attach a separate sheet if necessary.

(1)THIRD PARTY NAME

(1)THIRD PARTY STREET ADDRESS

(1)THIRD PARTY TELEPHONE

(1)THIRD PARTY CITY / STATE / ZIP

(2)THIRD PARTY NAME

(2)THIRD PARTY STREET ADDRESS

(2)THIRD PARTY TELEPHONE

(2)THIRD PARTY CITY / STATE / ZIP

14. If applicable, what is the status of your claim or lawsuit against the third party(ies)?

15. Are you, or will you be, represented by an attorney in connection with your claim or lawsuit against the third party?

☐ Yes ☐ No

a. If you answered "Yes" to question 15, please provide the contact information for your attorney.

ATTORNEY NAME

LAW FIRM

STREET ADDRESS

CITY / STATE / ZIP

TELEPHONE

EMAIL ADDRESS

16. List the names, addresses, and telephone numbers of all physicians and health care providers consulted for diagnosis or treatment relating to the subject injury or disease. Include approximate dates of consultation, if known. Please include all physicians or health care providers with whom you have appointments scheduled for additional medical services in the future that pertain to this injury or illness. Please attach a separate sheet if necessary.

(1)MEDICAL PROVIDER NAME

(1)MEDICAL PROVIDER STREET ADDRESS

(1)MEDICAL PROVIDER TELEPHONE

(1)MEDICAL PROVIDER CITY / STATE / ZIP

(1)DATE(S) OF TREATMENT

(1)REASON FOR VISIT

(2)MEDICAL PROVIDER NAME

(2)MEDICAL PROVIDER STREET ADDRESS

(2)MEDICAL PROVIDER TELEPHONE

(2)MEDICAL PROVIDER CITY / STATE / ZIP

(2)DATE(S) OF TREATMENT

(2)REASON FOR VISIT

(3)MEDICAL PROVIDER NAME

(3)MEDICAL PROVIDER STREET ADDRESS

(3)MEDICAL PROVIDER TELEPHONE

(3)MEDICAL PROVIDER CITY / STATE / ZIP

(3)DATE(S) OF TREATMENT

(3)REASON FOR VISIT

(4)MEDICAL PROVIDER NAME

(4)MEDICAL PROVIDER STREET ADDRESS

(4)MEDICAL PROVIDER TELEPHONE

(4)MEDICAL PROVIDER CITY / STATE / ZIP

(4)DATE(S) OF TREATMENT

(4)REASON FOR VISIT

17. List the names, addresses, and telephone numbers of ALL physicians and health care providers you have consulted for any other reason during the five (5) years preceding the onset of the injury or illness. Include approximate dates of consultation, if known. Please attach a separate sheet if necessary.

(1)MEDICAL PROVIDER NAME

(1)MEDICAL PROVIDER STREET ADDRESS

(1)MEDICAL PROVIDER TELEPHONE

(1)MEDICAL PROVIDER CITY / STATE / ZIP

(1)DATE(S) OF TREATMENT

(1)REASON FOR VISIT

(2)MEDICAL PROVIDER NAME

(2)MEDICAL PROVIDER STREET ADDRESS

(2)MEDICAL PROVIDER TELEPHONE

(2)MEDICAL PROVIDER CITY / STATE / ZIP

(2)DATE(S) OF TREATMENT

(2)REASON FOR VISIT

(3)MEDICAL PROVIDER NAME

(3)MEDICAL PROVIDER STREET ADDRESS

(3)MEDICAL PROVIDER TELEPHONE

(3)MEDICAL PROVIDER CITY / STATE / ZIP

(3)DATE(S) OF TREATMENT

(3)REASON FOR VISIT

(4)MEDICAL PROVIDER NAME

(4)MEDICAL PROVIDER STREET ADDRESS

(4)MEDICAL PROVIDER TELEPHONE

(4)MEDICAL PROVIDER CITY / STATE / ZIP

(4)DATE(S) OF TREATMENT

(4)REASON FOR VISIT

18. Include any further information you can offer to help the Board of Retirement in determining whether or not you meet the criteria for a disability retirement. Attach additional pages as necessary.

19. Are you, or will you be, represented in this application for disability retirement by an attorney?

☐ Yes ☐ No

a. If you answered "Yes" to question 19, please provide the contact information for your attorney.

ATTORNEY NAME

LAW FIRM

STREET ADDRESS

CITY / STATE / ZIP

TELEPHONE

EMAIL ADDRESS

20. Beneficiary nomination. NOTE: Nomination of beneficiary below supersedes any previous beneficiary election. You may add additional beneficiaries on a separate page, if necessary.

NAME

SOCIAL SECURITY NUMBER

RELATIONSHIP TO MEMBER

DATE OF BIRTH

MARRIAGE/DOMESTIC PARTNERSHIP REGISTRATION DATE (IF APPLICABLE)

21. FOR EMPLOYEES OF THE COUNTY OF MARIN, MARIN SUPERIOR COURT, MARIN/SONOMA MOSQUITO & VECTOR CONTROL, MARIN COMMUNITY SERVICES DISTRICT, TAMALPAIS COMMUNITY SERVICES DISTRICT, LAFCO, AND SOUTHERN MARIN FIRE ONLY:

Please indicate your current benefit coverage and whether you wish to continue that coverage as indicated below.

MEDICAL	Currently Have	Continue for Myself	Continue for My Dependents
Kaiser High	☐	☐	☐
Kaiser Low	☐	☐	☐
Kaiser Limited	☐	☐	☐
Blue Cross Prudent Buyer	☐	☐	☐
Blue Cross Prudent Buyer Classic	☐	☐	☐

DENTAL	Currently Have	Continue for Myself	Continue for My Dependents
Delta Dental	☐	☐	☐

DEPENDENT INFORMATION

NAME	DATE OF BIRTH	
		Full-time Student*? ☐ Yes ☐ No
		Full-time Student*? ☐ Yes ☐ No
		Full-time Student*? ☐ Yes ☐ No
		Full-time Student*? ☐ Yes ☐ No
		Full-time Student*? ☐ Yes ☐ No

* Must include documentation supporting full time enrollment in an accredited university or other educational institution.

PLEASE NOTE: This application does not replace any medical and/or other documentation which you may wish to submit in support of your application. It is the responsibility of the applicant to submit all supporting evidential data including, but not limited to, copies of all x-rays, MRI, CT scans, or any other tests or films, preferably on CD. Failure to submit all tests and records will delay consideration of your application.

YOU MUST PROVIDE THE ORIGINAL PLUS THREE (3) COPIES OF THE APPLICATION AND ALL SUPPORTING DOCUMENTATION YOU WISH TO SUBMIT

I hereby authorize MCERA to obtain my medical records, to contact the attorney identified on this application, or any attorney that I may appoint in the future, to discuss my application and my medical records. I have included the general medical release and Kaiser release forms with my application.

I declare under penalty of perjury that the foregoing is true and correct.

APPLICANT SIGNATURE _____ DATE _____

AUTHORIZED EMPLOYER SIGNATURE * _____ DATE * _____

* *Required only when department files on behalf of the employee.*

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AUTHORIZATION FOR RELEASE OF MEDICAL, PSYCHIATRIC AND EMPLOYMENT RECORDS AND INFORMATION

I, the undersigned, hereby authorize any and all physicians, hospitals, medical groups and other providers of health service, and Tristar Risk Management and/or any other Workers' Compensation insurer or adjuster, to release to the MARIN COUNTY EMPLOYEES' RETIREMENT ASSOCIATION (MCERA) any and all medical, psychiatric and psychological records, reports, or other writings relative to my past and present medical and/or psychological condition. I authorize the release of all medical, psychological and psychiatric records notwithstanding and with a waiver of California Assembly Bill 435, Civil Code §56 *et seq*., and Labor Code §§3751 and 3762 *et seq.*

The medical information disclosed pursuant to this authorization may be provided to the staff, Board and attorneys of the MCERA for use in connection with processing, adjudication and determination of my application for a disability retirement.

This authorization shall remain effective during the pendency of my application for a disability retirement or two (2) years after the date this release is signed by me, whichever date is earlier. I have been advised by this sentence that I have a right to a copy of this authorization. A photocopy of this signed authorization shall be as valid as the original.

I hereby authorize my past, present and future employers to release to the MCERA any and all records of my employment, including personnel records.

PRINT NAME	SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY / STATE / ZIP
APPLICANT SIGNATURE	DATE

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

MR #: _____

Name: _____

IMPRINT AREA

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

I understand that Kaiser Permanente will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

I hereby authorize:

KAISER PERMANENTE (ALL OFFICES)
Name of Disclosing Party

Address

City State ZIP

to disclose to:

MARIN COUNTY EMPLOYEES' RETIREMENT ASSN.
Name of Recipient

1 MCINNIS PARKWAY, FIRST FLOOR
Address

SAN RAFAEL, CA 94903
City State ZIP

records and information pertaining to:

Name of Member/Patient (List Other Names Used) Medical Record Number Date of Birth

Address Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (Date).

REVOCATION: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY RECORDS: Check the box, initial and/or sign to specify which type of information is to be disclosed.

- ☒ **MEDICAL INFORMATION** _____ (Initial)
- ☒ **PSYCHIATRIC INFORMATION** Signature _____ Date _____
- ☒ **DRUG/ALCOHOL INFORMATION** Signature _____ Date _____
- ☒ **RESULTS OF AN HIV TEST** Signature _____ Date _____
- ☒ **GENETIC RECORDS** Signature _____ Date _____
- ☒ **OTHER HEALTH INFORMATION** _____ (Initial) (specify below)

Specify the records to be disclosed: ALL RECORDS, TESTS AND FILMS FROM PAST 5 YEARS

The recipient may use the health information authorized on this form for the following purposes:
DISABILITY RETIREMENT

A copy of this authorization is as valid as the original.
Member/Patient has a right to a copy of this authorization.

Date Signature If Signed by Other than Member/Patient, Indicate Relationship