PERA
Public Employees Retirement Association of New Mexico
INVESTED IN TOMORROW.

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REEVALUATION APPLICATION FOR DISABILITY RETIREMENT BENEFITS FORM

Instructions: Please print or type in dark ink. The original of this form must be completed in its ENTIRETY and returned to PERA for processing.

Section I: General Information

Information regarding your disability application will not be released by PERA without your prior written consent

Please type or print so that others can read this information. Attach additional sheet(s) if necessary.

Name _____ SSN | | | | - | | | - | | | | |

Address _____

City _____ State _____ Zip _____

Birth Date _____ Daytime Phone No _____

Height _____ Weight _____

Name of Spouse _____ Birth Date _____

I am submitting an application for permanent disability retirement because I believe I am totally and permanently Disabled. The nature of my _____ illness _____ injury _____ condition is

_____

_____

_____

Is your illness, injury or condition a result of your job? _____ Yes _____ No

If yes, explain how _____

_____

_____

The reason(s) I cannot work are _____

_____

_____

_____

Section II: Employment Information

Current or Last Employer _____

Address _____

City _____ State _____ Zip _____

Name of Claimant: _____ Social Security Number: _____

This page must be completed in its ENTIRETY and returned to PERA for processing

Current Employment Status: ☐ not working effective date of leave without pay _____

terminated employment on _____

effective date of worker's comp _____

☐ working full time ☐ part time ☐ on leave ☐

FMLA ☐ _____

Current Position or Job Title _____

My job duties are _____

_____ *(Attach copy of job description*)

Work History: (*Include employers, job titles and dates starting with the most recent and back 10 to 15 years to give an idea of types of work you are capable of doing*.)

_____

_____

_____

(Attach copy of resume if necessary to provide complete educational or job history.)

My educational background is: *(check all that apply)*

grade school	_____	undergraduate	____	degree	_____
High school	_____	graduate	_____	degree	_____
GED	_____	post graduate	_____	degree	_____

List any job training or re-training you have received since your injury or illness: _____

_____

_____

List any degrees, certificates or licenses you have received since your injury or illness: _____

_____

_____

List any jobs or categories of work that you are currently capable of performing and which you are qualified to perform due to training and/or experience: _____

_____

_____

Section III: Disability Information

Date illness, injury or condition first occurred _____

Diagnosis _____ Date of Diagnosis _____

List the names and addresses of all physicians, hospitals or clinics who have examined and/or treated you in the last three years. Indicate the illness, injury or condition for which you were treated. Start with the most current and work back.
(Attach an extra page if necessary.)

Name of Claimant: _____ Social Security Number: _____

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Name	Location and telephone	Injury/Illness	Date Seen

Were you performing your regular duties at the time the disability occurred? _____

Do you consider this disability to have occurred as the natural and proximate result of causes arising solely and exclusively out of and in the course of your employment with an affiliated public employer? _____

If so, why? _____

_____

_____

Have you sustained injuries in previous accidents or have you suffered illness or condition of this nature on previous occasions? _____ If yes, give complete details on a separate page explaining how, when, and where the accident or illness occurred, the nature and extent of the injury or illness, and by whom you were employed at the time.

Are you now or have you ever received compensation from the Veteran's Administration for injuries or illness which occurred while in the military service? _____ If yes, give complete details on a separate page explaining how, when, and where the accident or illness occurred, and the nature and extent of the injury or illness.

_____ If yes, when did you apply? _____

Are you receiving monthly benefits? _____ If yes, what is the amount of your benefits? $ _____

Lump sum settlement? _____ If yes, amount of settlement? $ _____

Present status with Worker's Compensation? _____

_____

_____

Have you applied for federal social security benefits? _____ If yes, when did you apply? _____

Are you receiving monthly benefits? _____ If yes, what is the amount of your benefits? $ _____

If you have applied but are not receiving benefits, what is the status of your application? _____

_____

_____

By signature hereon, I declare that all information given is true and correct to the best of my knowledge and belief.

Applicant Signature: _____ Date: _____