GOVERNMENT EMPLOYEES RETIREMENT SYSTEM
3438 Kronprindsens Gade, GERS Complex - Ste. 1, St. Thomas, VI 00802-5750 • (340) 776-7703 • Fax (340) 776-4499
3005 Orange Grove, Lot 5, Christiansted, St. Croix, VI 00820-4313 • (340) 773-5480 • Fax (340) 773-5497
www.usvigers.com

NON-DUTY DISABILITY GUIDELINES

(Governed by Title 3 VIC, Section 710)

REQUIREMENTS:

- Must be under age 60.
- Disability cases must be supported by medical reports including X-rays reports, operative reports, therapy and findings.
- Must have nine (9) or more years of credited service.
- Disability must cause the member to be totally and permanently incapacitated for service.
- Benefits of 2% for each credited year.
- Disability must not be job related.
- Must be certified disabled by at least two (2) physicians designated by the GERS.
- Diseases/Illnesses such as, but not limited to, stroke, renal failure, cancer, physical and mental disability and blindness are used for disability benefits.
- Disability cases, including all medical reports, are reviewed by our disability organization, Alternatives for Growth (AFG), which is on the mainland. AFG advises the GERS on speciality of physician that the member must see.
- Disability cases normally take several months.

SPECIAL NOTES:

- Member must not resign or retire until case is completed by the GERS.
- Disability applicant must contact the Group Health Insurance Office for continued health coverage.
- Member may also file for disability with the Social Security Administration.
- Disability applicant must keep their GERS loan(s) payments current.
- Should a disability case be approved, contributions due the System for service credit must be paid prior to being placed on the Annuity Payroll.

I hereby acknowledge that the preceding guidelines were read and thoroughly explained to me

on _____ by _____
Date GERS Representative

Signature of Member _____

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NON-DUTY DISABILITY APPLICATION

PERSONAL INFORMATION:

Name _____
(Last) (First) (Middle)

Mailing Address _____

Physical Address _____

Social Security # _____ Date of Birth _____

Home Phone #_____ Cell Phone #_____

Are you married? Yes _____ No _____ If yes, Spouse's Name _____

EMPLOYMENT INFORMATION:

Place of Employment _____

Work Address _____

Work Phone # _____ Ext. _____

Approximate years of service _____ Employee #_____

Position Title_____ Are you a Veteran? Yes _____ No _____

Name and Title of Immediate Supervisor _____

Last date you worked _____

Date removed from payroll due to disability _____

YOUR DISABILITY:

Nature of your disability _____

Date you first became disabled _____

Date first treated for this disability _____

Have you been completely unable to work during your disability? Yes _____ No _____

YOUR ATTENDING PHYSICIAN(S):

Name of your physician _____

Physician's address _____

Phone #_____ Date of first treatment _____

Please list other Medical/Psychological Treatment of all physicians consulted for medical or psychological treatment within the last two years (treatment that was not directly related to your current disabling condition):

Name of your physician _____

Physician's address _____

Phone #_____ Date of first treatment _____

Nature or cause of treatment _____

_____

Name of your physician _____

Physician's address _____

Phone #_____ Date of first treatment _____

Nature or cause of treatment _____

_____

Name of your physician _____

Physician's address _____

Phone #_____ Date of first treatment _____

Nature or cause of treatment _____

_____

SOCIAL SECURITY ADMINISTRATION:

Have you applied for Social Security Disability? Yes _____ No _____

If yes, have you received a decision on your application? Yes _____ No _____

If yes, has it been approved or rejected? Approved _____ Rejected _____

If it has been approved, please submit together with this application the Certificate of Social Security Insurance Award.

AUTHORIZATION FOR RELEASE OF INFORMATION:

I hereby apply for non-duty 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 Employees' Retirement System of the Government of the Virgin Islands, 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, 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 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.

Signed _____ Date _____

(Employee or Legal Guardian)

Name of Legal Guardian _____

Mailing Address _____

Physical Address _____

Telephone # _____

APPLICANT'S ACKNOWLEDGMENT:

I hereby apply for a NON-DUTY DISABILITY ANNUITY from the Employees' Retirement System of the Government of the Virgin Islands. The above statements are true to the best of my knowledge and belief. I understand that a false statement may disqualify me for benefits, and that the Board of Trustees shall have the right to recover any payments made to me. I also agree that I will advise the Employees' Retirement System of my return to any type of work, and I will return any payments to which I am not entitled by reason of my return to work, termination of disability, or receipt of benefits from other sources listed above.

_____ _____

Signature of Witness Signature of Applicant

_____ _____

Date Date