



City of Newport News
Employees' Retirement Fund
 2400 Washington Ave
 Newport News, VA 23607
 Phone: (757) 926-3929
 Fax: (757) 926-3570

Disability Retirement Application Procedures

Eligibility to Apply for Disability Retirement:	
<ul style="list-style-type: none"> ✓ Vested employee of NNERF ✓ For NNPS employees, not provided retirement benefits through VRS ✓ Not eligible for regular service retirement based on age or service 	<ul style="list-style-type: none"> ✓ In an active pay status ✓ Not currently working

Application Procedures:		
	City Responsibilities	Applicant Responsibilities
1. Initiate claim by submitting completed Application for Disability Retirement to Department of Finance	<ul style="list-style-type: none"> - Provide copy of application at request of applicant - Communicate with applicant regarding information needed for application 	<ul style="list-style-type: none"> - Request and complete application - Provide all requested information, including physician reports and documentation
2. Undergo Independent Medical Evaluation (IME) by City's disability physician	<ul style="list-style-type: none"> - Schedule appointment for applicant with City's physician - Pay for IME if applicant reports to scheduled appointment 	<ul style="list-style-type: none"> - Report to appointment as scheduled - Provide information to the City's physician as requested - Repay NNERF if appointment is missed
3. Case reviewed by Disability Review Committee. Committee provides recommendation to Retirement Board. Case reviewed by Board.	<ul style="list-style-type: none"> - Provide all pertinent information, including IME, to Committee - Provide applicant with date and time of Committee meeting - Provide applicant with date and time of Retirement Board meeting 	<ul style="list-style-type: none"> - If desired, appear and testify before the Committee and/or Board
Retirement Board reaches decision on applicant.		
If benefit is approved:	<ul style="list-style-type: none"> - Inform applicant of Board's decision - Begin payment of benefit - Communicate with member regarding future requests for information from Committee or Board 	<ul style="list-style-type: none"> - Maintain updated contact and direct deposit information with Department of Finance - Provide all information, including undergoing additional medical examinations, as requested by Committee or Board
If benefit is denied:	<ul style="list-style-type: none"> - Inform applicant of Board's decision 	<ul style="list-style-type: none"> - If reconsideration is desired, request reconsideration in writing. See full Administrative Rules and Regulations.

I certify that the procedures for applying for a disability benefit have been explained to me, that I understand the requirements to apply for a disability benefit, and that I have received a copy of the Administrative Rules and Regulations for disability benefits:

Signed:

Date: _____



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Application for Disability Retirement

PERSONAL INFORMATION		Office Use Only	
Name: (Last, First, Middle Initial)	Social Security Number:		Retiree EIN
Date of Birth: (mm/dd/yyyy)	Age:		Dept/Class
Mailing Address: (Street, City, Zip)	Phone Number		Sx/Rc/Mar
Email Address: (Please provide an email address to receive communications and pay notifications for your benefit if approved. A passcode is required; it will be your last four of your SSN.)			Pay Code Occ 180/181 NonOcc 182/183
			Annual Pay
CERTIFICATION			Period Pay
Length of Service with City Retirement:			Revision Date
From:	To: <input type="checkbox"/> Broken Service		Credited Svc YRS / MOS
Reason for Applying for Disability Retirement: (Attach additional sheets if necessary)			FIT
<p>Was disability a result of an accident while on duty? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:</p>		SIT	
Attending Physicians: (Attach additional sheets if necessary)		Credit Union	
Name:	Address:	Direct Deposit	
		Life 8040/8041	
<p>I hereby certify: 1) All information provided in this document is true, 2) I have read and understand the Administrative Rules and Regulations for disability benefits and agree to abide by all City ordinances related to disability benefits, 3) I will submit to any medical or functional capacity examination requested by NNERF, 4) I will notify NNERF within thirty (30) days of any material change in my medical condition, or of any gainful activity in which I become engaged, and 5) I will notify NNERF within thirty (30) days of any payments received pursuant to the Virginia Workers' Compensation Act, any disability benefits received from the Social Security Administration, and any other compensation received from the City under any other agreement. Additionally, I agree that, in the event that NNERF pays benefits in excess of those to which I am entitled, I will repay the excess to NNERF.</p>		Health 8000 PPO1/HMO/HDHP EMP/E1D/ESP/FAM	
<p>I hereby make application for <input type="checkbox"/> Occupational <input type="checkbox"/> Non-Occupational disability retirement effective: ____/01/____</p>		Dental 8030 EMP/E1D/ESP/FAM	
Signed:	Witness:	Vision 8060 EMP/E1D/ESP/FAM	
_____	_____		
Date: _____	Date: _____	Fitness 8052/8051/8053 EMPL/SPOU/ BOTH/FAM	
<p>Note: Please include a copy of your most recent physician reports and any other documentation you would like considered with this application.</p>			



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Application for Disability Retirement Insurance Elections

Information Regarding Disability Retirement and Insurance:

If approved, you may continue the health coverages in effect as of the effective date of disability as defined in the Administrative Rules and Regulations for Disability Benefits. Please select which coverages you wish to continue if approved for disability retirement. Any coverage elected will be effective the first of the month following approval. **In accordance with City Code Sec. 31-110(c), members who decline retiree coverage on their application may not subsequently enroll.**

INSURANCE ELECTIONS

		Office Use
Health Pre-65: <input type="checkbox"/> Accept <input type="checkbox"/> Decline <div style="display: flex; justify-content: space-around;"> Anthem <input type="checkbox"/> POS 750 <input type="checkbox"/> POS 1500 <input type="checkbox"/> HDHP </div> Dependent Name(s): _____ REL: ____ SSN: _____ DOB: _____ _____ REL: ____ SSN: _____ DOB: _____ _____ REL: ____ SSN: _____ DOB: _____	<input type="checkbox"/> Retiree <input type="checkbox"/> Retiree +1Child <input type="checkbox"/> Retiree + Spouse <input type="checkbox"/> Family	8000 POPT 750/1500/ HDHP EMP/EID/ ESP/FAM
Dental: <input type="checkbox"/> Accept <input type="checkbox"/> Decline Dependent Name(s): _____ REL: ____ SSN: _____ DOB: _____ _____ REL: ____ SSN: _____ DOB: _____ _____ REL: ____ SSN: _____ DOB: _____	<input type="checkbox"/> Retiree <input type="checkbox"/> Retiree +1Child <input type="checkbox"/> Retiree + Spouse <input type="checkbox"/> Family	8030 PDEL DD01 EMP/EID/ ESP/FAM
Vision: <input type="checkbox"/> Accept <input type="checkbox"/> Decline Dependent Name(s): _____ REL: ____ SSN: _____ DOB: _____ _____ REL: ____ SSN: _____ DOB: _____ _____ REL: ____ SSN: _____ DOB: _____	<input type="checkbox"/> Retiree <input type="checkbox"/> Retiree +1Child <input type="checkbox"/> Retiree + Spouse <input type="checkbox"/> Family	8060 PVSP PVSP EMP/EID/ ESP/FAM Level:0001
Fitness Center: : <input type="checkbox"/> Accept <input type="checkbox"/> Decline <div style="display: flex; justify-content: space-around;"> <input type="checkbox"/> OneLife <input type="checkbox"/> Riverside Wellness <input type="checkbox"/> YMCA </div> Dependent Name(s): _____ REL: ____ SSN: _____ DOB: _____ _____ REL: ____ SSN: _____ DOB: _____ _____ REL: ____ SSN: _____ DOB: _____	<input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Both <input type="checkbox"/> Family (YMCA ONLY)	8052/8051/ 8053 ONEL/RSWC/ YMCA ONEL/RSWC/ YMCA EMPL/SPOU/ BOTH/FAM Level 0001

I understand only approved applicants are eligible for retiree coverage under NNERF and that no coverage is provided by the Fund at this time. I understand other continuing coverage options, including COBRA continuing coverage, may be available to me after termination of employment and that I am responsible for electing these coverages separately if desired. I understand if I am approved, the retiree coverage elected above will be effective the first of the month following the date the Board approves my application, and that if I am not approved, no coverage will be offered by NNERF. I also understand if I decline coverage at this time, I will be ineligible to enroll in the future.

Signed:

Date: _____