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:

- ✓ Vested employee of NNERF
- ✓ For NNPS employees, not provided retirement benefits through VRS
- ✓ Not eligible for regular service retirement based on age or service
- ✓ 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	- Provide copy of application at request of applicant - Communicate with applicant regarding information needed for application	- Request and complete application - Provide all requested information, including physician reports and documentation
2. Undergo Independent Medical Evaluation (IME) by City's disability physician	- Schedule appointment for applicant with City's physician - Pay for IME if applicant reports to scheduled appointment	- 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.	- 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	- If desired, appear and testify before the Committee and/or Board
Retirement Board reaches decision on applicant.		
If benefit is approved:	- Inform applicant of Board's decision - Begin payment of benefit - Communicate with member regarding future requests for information from Committee or Board	- 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:	- Inform applicant of Board's decision	- 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: _____

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

Application for Disability Retirement

PERSONAL INFORMATION

Name: (Last, First, Middle Initial)	**Social Security Number:**
Date of Birth: (mm/dd/yyyy)	**Age:**
Mailing Address: (Street, City, Zip)	**Phone Number**

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.)

CERTIFICATION

Length of Service with City Retirement:

From:	**To:** ☐ Broken Service

Reason for Applying for Disability Retirement: (Attach additional sheets if necessary)

Was disability a result of an accident while on duty? ☐ **Yes** ☐ **No**
If yes, please explain:

Attending Physicians: (Attach additional sheets if necessary)

Name:	**Address:**

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.

I hereby make application for ☐ **Occupational** ☐ **Non-Occupational** disability retirement effective: _____**/01/**_____

Signed: _____

Date: _____

Witness: _____

Date: _____

Office Use Only

Retiree EIN

Dept/Class

Sx/Rc/Mar

Pay Code
Occ 180/181
NonOcc 182/183

Annual Pay

Period Pay

Revision Date

Credited Svc
YRS / MOS

FIT

SIT

Credit Union

Direct Deposit

Life
8040/8041

Health 8000
PPO1/HMO/HDHP
EMP/E1D/ESP/FAM

Dental 8030
EMP/E1D/ESP/FAM

Vision 8060
EMP/E1D/ESP/FAM

Fitness
8052/8051/8053
EMPL/SPOU/
BOTH/FAM

Note: Please include a copy of your most recent physician reports and any other documentation you would like considered with this application.

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

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: ☐ **Accept** ☐ **Decline** **Anthem** ☐ PPO ☐ HealthKeepers ☐ HDHP Dependent Name(s): _____ REL: ___ SSN: _____ DOB: _____ _____ REL: ___ SSN: _____ DOB: _____ _____ REL: ___ SSN: _____ DOB: _____	☐ Retiree ☐ Retiree +1Child ☐ Retiree + Spouse ☐ Family	8000 PATH PPO1/HMO/ HDHP EMP/E1D/ ESP/FAM
Dental: ☐ **Accept** ☐ **Decline** Dependent Name(s): _____ REL: ___ SSN: _____ DOB: _____ _____ REL: ___ SSN: _____ DOB: _____ _____ REL: ___ SSN: _____ DOB: _____	☐ Retiree ☐ Retiree +1Child ☐ Retiree + Spouse ☐ Family	8030 PDEL DD01 EMP/E1D/ ESP/FAM
Vision: ☐ **Accept** ☐ **Decline** Dependent Name(s): _____ REL: ___ SSN: _____ DOB: _____ _____ REL: ___ SSN: _____ DOB: _____ _____ REL: ___ SSN: _____ DOB: _____	☐ Retiree ☐ Retiree +1Child ☐ Retiree + Spouse ☐ Family	8060 PVSP PVSP EMP/E1D/ ESP/FAM Level:0001
Fitness Center: : ☐ **Accept** ☐ **Decline** ☐ **OneLife** ☐ **Riverside Wellness** ☐ **YMCA** Dependent Name(s): _____ REL: ___ SSN: _____ DOB: _____ _____ REL: ___ SSN: _____ DOB: _____ _____ REL: ___ SSN: _____ DOB: _____	☐ Retiree ☐ Spouse ☐ Both ☐ Family (YMCA ONLY)	8052/8051/ 8053 GOLD/RSWC/ YMCA GOLD/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: _____