

# ARKANSAS STATE HIGHWAY EMPLOYEES' RETIREMENT SYSTEM APPLICATION FOR DISABILITY RETIREMENT

Date \_\_\_\_\_

**TO THE BOARD OF TRUSTEES:**

In accordance with the provisions of Act 454 of 1949, I, the undersigned, a member of the system, hereby make application for retirement from active service as \_\_\_\_\_ District \_\_\_\_\_ Division \_\_\_\_\_ on account of disability which disqualifies me for active service. I further specifically acknowledge that the use of any and all documents submitted as part of this application and any and all documents or other items considered by the Arkansas State Highway Employees' Retirement System ('ASHERS') is limited to the consideration of this application only. I further specifically and irrevocably waive the use of any decision of ASHERS in any proceeding before or related to the Arkansas Workers' Compensation Commission.

\_\_\_\_\_  
Signature of Applicant

1. Applicant's full name \_\_\_\_\_
2. Date of Birth \_\_\_\_\_
3. Social Security Number \_\_\_\_\_
4. Present Address \_\_\_\_\_
5. Where last employed \_\_\_\_\_
6. When ceased to be employed? \_\_\_\_\_
7. Were you compelled to stop work by reason of your present illness? \_\_\_\_\_
8. How much have you earned at gainful work since you ceased to be employed by the Arkansas Department of Transportation?  
Amount Earned \$ \_\_\_\_\_ Explain \_\_\_\_\_
9. When did you first consult a physician for your present illness? \_\_\_\_\_
10. Has your condition shown improvement? \_\_\_\_\_
11. Are you able to engage in any gainful employment? \_\_\_\_\_
12. Nature of complaint? \_\_\_\_\_
13. Give name and address of present attending physician and other physicians consulted:  

Name _____	Name _____
Address _____	Address _____
_____	_____
14. List institutions, if any, at which treatment has been received for conditions causing present disability:  

Name of Institution _____	Address _____
_____	_____
_____	_____

**DO NOT USE THIS BLOCK**

DISABILITY RETIREMENT ANNUITY

PERIOD OF PAYMENT	Monthly Annuity	Deduction	Net Pay	Prepared By	Verified By	APPROVED
First Month of Fraction Thereof						
Each Month Thereafter						

(A fully executed original and duplicate of this form must be filed with the Executive Secretary when disability retirement is desired)

**ARKANSAS STATE HIGHWAY EMPLOYEES' RETIREMENT SYSTEM  
APPLICATION FOR DISABILITY RETIREMENT (Con't)**

**STRAIGHT LIFE**

I herewith request a straight life annuity in lieu of Option A or Option B explained below.

Date \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

**OPTION A**

I elect to receive an amount calculated to provide an actuarially equivalent benefit under Arkansas Code 24-5-118, payable to me for life or for period of one hundred twenty (120) monthly payments. My designated beneficiary is:

**BENEFICIARY INFORMATION:**

Name \_\_\_\_\_

Address \_\_\_\_\_

Social Security Number \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

**OPTION B**

I elect to receive an amount calculated to provide an actuarially equivalent benefit under Arkansas Code 24-5-118, payable for my life and 1/2 of my annuity to my beneficiary at the time of my death. My designated beneficiary is:

**BENEFICIARY INFORMATION:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Social Security Number \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

**FORM MUST BE NOTARIZED**

Subscribed and sworn to before me a Notary Public in and for the County and State aforesaid, this  
the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

My Commission Expires \_\_\_\_\_ Notary Public \_\_\_\_\_

# Arkansas State Highway EMPLOYEES' RETIREMENT SYSTEM



HIGHWAY DEPARTMENT BUILDING • P.O. Box 2261 • Little Rock, Arkansas 72203 • 569-2411

## HIPAA AUTHORIZATION FORM

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person, or class of persons, or facility, is authorized to make disclosure.  
Submit a form for each provider care.

\_\_\_\_\_

2. The following person, Robyn M. Smith, or class of persons may receive disclosure of protected health information about me:

Arkansas State Highway Employees' Retirement  
P.O. Box 2261 Little Rock, AR 72203

3. The specific information that should be disclosed is:

Any and all information you may give regarding the medical condition for which I have consulted you, including history, findings, diagnosis, treatment given, condition now or at discharge and prognosis.

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying Robyn M. Smith in writing. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

6. This authorization expires on \_\_\_\_\_, 20\_\_\_\_, OR upon occurrence of the following event that relates to me or to the purposed of the intended use or disclosure of information about me:

\_\_\_\_\_.

7. This form is for the purpose of receiving information to ascertain if the employee qualifies for Disability Retirement.

**THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.**

\_\_\_\_\_  
Signature of Individual  
(The person about whom the information relates)

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Date of Birth or Social Security Number

--OR, if applicable--

\_\_\_\_\_  
Signature of Guardian or  
Personal Representative

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Date of Guardianship