

Beginning the Disability Process

You may apply for disability benefits if your physician has stated that you are unable to work for more than 90 consecutive days while recovering from an illness or injury.

Disability certification

The Board of Pensions must certify any disability. You may be considered disabled if

- you are unable to perform your regular work duties due to sickness or bodily injury, or
- after 24 consecutive months of a certified disability, due to sickness or bodily injury, you cannot perform any type of work for which you are suited by education, training, and/or experience.

Applying for benefits

Follow these steps to apply for disability benefits:

- Call 800-773-7752 (800-PRESPLAN) to request a confidential intake interview with a Board Disability Specialist. This allows the Board to open a claim for you with Lincoln Financial Group, the disability medical case manager.
- Be prepared to provide your name, Social Security number, last day worked, phone number, employer and physician contact information, and job description. Ask any questions you may have about the disability claims process.
- Download the [disability information packet](#) from pensions.org, or ask for a copy by mail. Complete the packet and email (memberservices@pensions.org), fax (215-587-6215), or mail it [The Board of Pensions of the Presbyterian Church (U.S.A.), 2000 Market St., Phila., PA 19103-3298], with a *copy of your job description*, to your Disability Specialist at the Board.

If you are physically or mentally unable to complete the packet, a power of attorney or authorization form must be included with the completed packet or on file with the Board or Lincoln Financial, allowing a designee to act on your behalf.

Lincoln Financial will

- send you or your designee a form for the attending physician and a form to grant authorization to obtain and release medical records;
- notify you or your designee when your forms are received;
- contact the attending physician; and
- make a recommendation on your application for disability benefits.

Application time limit

If you are otherwise eligible, and you do not apply for the benefit when the disability begins, you may still apply if less than 12 months have elapsed since the disability began.

The Board will make a final determination on whether to certify you as disabled.

If you have questions about the claims process, call Lincoln Financial Group at 800-838-5290. For answers to Benefits Plan questions, call the Board at 800-773-7752 (800-PRESPLAN).

As of May 1, 2018, Liberty Life Assurance Company of Boston, the parent company of Liberty Mutual, became a wholly owned subsidiary of the Lincoln National Life Insurance Company, a Lincoln Financial Group company. As the transition to the Lincoln name takes place over the coming months, you may see references to Liberty Mutual, Liberty Mutual Benefits a Lincoln Financial Group Company, or Lincoln Financial Group. Please open and read all correspondence you receive about your benefits.

Before completing this form, call 800-773-7752 (800-PRESPLAN) to request a confidential interview with a Board of Pensions Disability Specialist. Be prepared with your name, Social Security number, last day worked, phone number, employer and physician contact information, and job description. Your Disability Specialist will explain how to process this form.

Member information

Name			Last 4 digits of SSN
Address			
City	State	ZIP	
Phone ()	Fax ()	Email	

Work status

When did you become incapable of performing the material duties of your regular occupation because of your condition?

What is the last date you worked: Full time Part time # of hours _____

On what date will your salary relationship terminate? _____

On what date do you expect to return to work? _____

How does your disabling condition prevent you from performing the material duties of your regular occupation?

Social Security and Medicare status

Did you opt out of Social Security as a minister? Yes No N/A

If yes, are you eligible for Social Security benefits from previous employment? Yes No

Are you receiving SSDI, SSRI, or SSI benefits? Yes* No Date of eligibility _____

** Send copy of award letter to the Board.*

Are you enrolled in

Medicare Part A	<input type="checkbox"/> Yes* <input type="checkbox"/> No	Date _____
Medicare Part B	<input type="checkbox"/> Yes* <input type="checkbox"/> No	Date _____
Medicare Part D	<input type="checkbox"/> Yes* <input type="checkbox"/> No	Date _____

Are any of your dependents enrolled in

Medicare Part A	<input type="checkbox"/> Yes* <input type="checkbox"/> No	Date _____
Medicare Part B	<input type="checkbox"/> Yes* <input type="checkbox"/> No	Date _____
Medicare Part D	<input type="checkbox"/> Yes* <input type="checkbox"/> No	Date _____



Are you receiving dialysis treatment?
 Yes No Date of first dialysis treatment_____

Do any of your dependents receive dialysis treatment?
 Yes No Date of first dialysis treatment_____

* Send a copy of Medicare cards to the Board.

Member's name _____

Other medical coverage

Do you have medical coverage other than through the Benefits Plan of the PC(USA)? Yes No
(If yes, then complete below.)

Name _____

Address _____

Policy # _____

Subscriber name _____

Subscriber birth date _____

Other benefits

Have you applied for benefits under:	Applied		Date applied	Determination	
	Yes	No		Eligible	Not eligible
Social Security disability	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Social Security retirement	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Veteran's benefits	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Workers' compensation	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Motor vehicle insurance	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Employer's disability policy	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Other government programs	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Other benefits	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Have you received any payment as a result of your disability from a third party not listed above? Yes No

If yes, provide copy of the award information.

Have you ever received any disability benefit for a previous condition? Yes No

If yes, describe the disability, the benefit source, the dates of disability and disability payments:



Member's name _____

Do you have long-term care insurance? Yes No

Have you applied for vocational rehabilitation services? Yes No

If yes, provide the organization name, telephone, contact person and status of application: _____

Dates: _____

Dental benefits

If you wish to continue the dental coverage in effect before your disability, complete the following. I understand that the Board will withhold the cost of my dental coverage from my disability check. I would like to continue:

	PPO	DMO
Member	<input type="checkbox"/>	<input type="checkbox"/>
Member + spouse	<input type="checkbox"/>	<input type="checkbox"/>
Member + children	<input type="checkbox"/>	<input type="checkbox"/>
Member + children with orthodontia	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>
Family with orthodontia	<input type="checkbox"/>	<input type="checkbox"/>

Note:

The only change a member can make to his or her dental coverage during a period of disability is from PPO to DMO or from DMO to PPO. A member is not permitted to add anyone to the coverage during disability.

Authorization

I declare that to the best of my knowledge and belief, the information provided above and the benefits application information I provided in support of my disability benefit application is complete and true. I understand that the Benefits Plan authorizes the Board to suspend or terminate payment of disability benefits if I fail to provide the Board with documentation requested by the Board or its vendor partners to substantiate any earned income, Social Security Disability Insurance, or other information.

Member's signature *(required)* _____

Date *(mm/dd/yyyy)* _____



Member's name _____

Tax withholding election

If you do not return this completed form to the Board of Pensions, federal and state tax may be withheld from your disability payment based on the requirements of the Internal Revenue Service and your state of residency.

Federal

Indicate whether you want federal income tax withheld from your monthly disability payment. To determine your withholding allowances, visit the IRS website (irs.gov/pub/irs-pdf/p15.pdf).

No federal withholding

NO, do not withhold federal income tax from my disability payment. (If selected, go to State section below.)

Request federal withholding

YES, withhold federal income tax from my disability payment based on the information provided in items 1 through 3 below.

1. Number of allowances *(If you are requesting withholding but have no allowances, enter "0.")* _____
2. Marital status *(check one)* Single Married Married but withholding at higher, single rate
3. Additional amount, if any, you wish to have withheld from your monthly disability payment *(Note: You may not enter an amount here without first entering the number of allowances, including zero, on line 1.)* \$ _____

State

If you do not reside in one of the states listed in the two paragraphs below, please go to Member's signature, below. Consult your personal tax professional and/or your state's tax withholding instructions for guidance to complete this form.

- If you reside in ARKANSAS, CALIFORNIA, DELAWARE, GEORGIA, IOWA, KANSAS, MAINE, MICHIGAN, NORTH CAROLINA, OKLAHOMA, OREGON, VERMONT, or VIRGINIA, you may elect to have state income tax withheld regardless of your federal income tax election. State income tax withholding is not required by these states if federal income tax is withheld; however, you must make a clear election. Please make the appropriate election by checking one of the boxes below.
- If you reside in MASSACHUSETTS or NEBRASKA, you must have state income taxes withheld, unless you elected to NOT have federal income tax withheld from your disability payment. If you elect to have federal income tax withheld and you do not make a state income tax election, state income tax withholding will be made based on what is required by your state of residency.

Indicate your state of residency for tax purposes: _____



No state withholding

NO, do not withhold state income tax from my disability payment.

Request state withholding

YES, withhold state income tax from my disability payment based on the information provided in items 1 through 3 below.

- 1. Number of allowances (If you are requesting withholding but have no allowances, enter "0.") _____
- 2. Marital status *(check one)* Single Married Married but withholding at higher, single rate
- 3. Additional amount, if any, you wish to have withheld from your monthly disability payment *(Note: You may not enter an amount here without first entering the number of allowances, including zero, on line 1.)* \$ _____

Member's signature *(required)* _____

Date *(mm/dd/yyyy)* _____

Direct deposit *(Required)*

Account information

Name of financial institution _____

Routing number *(9-digit number)* _____

Member's bank account number _____

Account type: Checking account Savings account

On behalf of myself, my legal representative, and my executor or administrator, I authorize the electronic deposit of my benefit payment to the account listed above. I agree to repay the Board of Pensions any benefit amount erroneously credited to my account. I authorize the Board of Pensions to offset and recoup from my account any benefits paid or due to me or to my estate, survivors, designated beneficiaries, or heirs at law to recover any amount erroneously credited to my account under this authorization. This agreement shall survive the termination of the direct deposit authorization.

This authorization shall remain in effect until the Board of Pensions receives written notification from me of its termination in such a time and manner as to afford the Board of Pensions and the financial institution named above a reasonable opportunity to act on it.

Member's signature *(required)* _____

Date *(mm/dd/yyyy)* _____