



## AFFIDAVIT OF APPLICANT FOR CLASSROOM DISABILITY BENEFIT

State Form 21703 (R6 / 8-11)  
Approved by State Board of Accounts, 2011

**INDIANA PUBLIC RETIREMENT SYSTEM  
TEACHERS' RETIREMENT FUND**  
1 North Capitol Avenue, Suite 001  
Indianapolis, IN 46204-2014  
Telephone: (888) 286-3544 (Toll-free)  
Fax: (317) 232-3882 / E-mail: [questions@inprs.in.gov](mailto:questions@inprs.in.gov)  
Web site: [www.inprs.in.gov](http://www.inprs.in.gov)

Your Social Security number is being requested by this agency pursuant to the requirements of IRS Code 3405. This disclosure is mandatory and this form cannot be processed without this information

### INSTRUCTIONS

1. Read the application before entering information on the application.
2. Type or print using black ink. Complete all information and place the Member's name, Social Security number (last 4 digits), and Pension ID (PID) number at the top of each page as requested.
3. Direct questions to Customer Service, Toll-free at (888) 526-1687, Monday – Friday, 8 a.m.- 8 p.m. EST. The agency is closed on weekends and State-approved holidays.

### IMPORTANT INFORMATION

1. The member must complete the information requested in this affidavit and provide this completed affidavit and the [Attending Physician's Statement for a Classroom Disability Benefit \(State Form 17296\)](#) to the member's attending physician.
2. In compliance with Health Information Portability and Accountability Act (HIPAA) regulations, this form cannot be faxed or e-mailed because of the personal health information (PHI) contained in the document.
3. The member's attending physician must submit this completed affidavit and the completed *Attending Physician's Statement for a Classroom Disability Benefit (State Form 17296)* to the Fund physician appointed by the INPRS Board of Trustees.
4. The Fund physician reviews the documents and makes a determination that is then provided to the INPRS, Teachers' Retirement Fund (TRF).
5. TRF notifies the member of the determination.

### MEMBER INFORMATION

|               |       |   |                                   |                         |                                 |
|---------------|-------|---|-----------------------------------|-------------------------|---------------------------------|
| Member's name |       | Social Security number <i>(last 4 digits)</i> |                                   | Pension ID (PID) number |                                 |
| Address       |       |   | Date of birth <i>(mm/dd/yyyy)</i> |                         | Telephone number with area code |
| City          | State | ZIP Code                                      | E-mail address                    |                         |                                 |

### LAST EMPLOYER INFORMATION

|   |                        |   |      |                                   |          |
|---|------------------------|---|------|-----------------------------------|----------|
| Last employer   |                        | Employer city or township                         |      | Employer county                   |          |
| Last date of active teaching service<br><i>(mm/dd/yyyy)</i> | Last teaching position | Date covered service began<br><i>(mm/dd/yyyy)</i> |      | Member's age at beginning service |          |
| President of Board or Trustee of last employer              |                        | Superintendent of last employer                   |      |                                   |          |
| Address of President of Board or Trustee of last employer   |                        | Address of Superintendent of last employer        |      |                                   |          |
| City  | State                  | ZIP Code  | City | State                             | ZIP Code |

### MEDICAL INFORMATION

|  |  |  |   |
|--|--|--|---|
| Date medical condition began<br><i>(mm/dd/yyyy)</i>                | Date you gave up your teaching position<br><i>(mm/dd/yyyy)</i>                           | Date you first consulted a physician for this condition<br><i>(mm/dd/yyyy)</i> | Date your last school year ended<br><i>(mm/dd/yyyy)</i> |
| Date your next school year starts<br><i>(mm/dd/yyyy)</i>           | Date a half school year will have elapsed since you quit teaching<br><i>(mm/dd/yyyy)</i> | Time lost during last teaching year because of your condition                  | Earnings, if any, since you ceased public school work   |
| Name of attending physician you first consulted for this condition |  | Address of attending physician   |   |

How did your disability begin? State fully all the symptoms and describe your condition from onset of symptoms:

|  |  |  |   |
|--|--|--|---|
| Are you confined to bed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Are you confined to a house?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Date confinement, if any, began<br><i>(mm/dd/yyyy)</i> | Do you expect such confinement to continue?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|--|---|

|               |   |                         |
|---------------|---|-------------------------|
| Member's name | Social Security number <i>(last 4 digits)</i> | Pension ID (PID) number |
|---------------|---|-------------------------|

**MEDICAL INFORMATION (Continued)**

Describe, in detail, to what extent you are incapacitated from continuing in the teaching profession.

What ailments, diseases, illnesses, disorders, infirmities, disabilities or injuries have you had in the last five years? Give complete facts, dates of onset, and the name and address of any physician who attended you in each case.

Have you ever been an inmate of a hospital, asylum, sanitarium, or health resort of any kind? If so, give dates, sites, and full particulars.

During the last five years have you received a pension from any source, or benefits from any accident or health insurance company or association? If so, provide dates, names, addresses and full particulars.

Give name and address of every physician and/or specialist you have consulted during the last three years.

Have you made claim to any insurance company for benefits because of your condition? If so, give name and address of each such insurance company.

Are you able to appear before the examining physician in Indianapolis?  Yes  No

If not, can you appear before an examining physician in your area?  Yes  No

**MEMBER AFFIDAVIT**

I hereby acknowledge that I understand the terms of this affidavit and any ambiguities herein are to be resolved in favor of the Teachers' Retirement Fund. I hereby acknowledge that I have had ample time and opportunity to secure legal counsel for the purpose of explaining any of these declarations contained within. I affirm, under the penalties for perjury, that the foregoing representation(s) is (are) true.

Member's signature

Member's name *(printed)*

Date *(mm/dd/yyyy)*

**NOTARY PUBLIC CERTIFICATION**

State of \_\_\_\_\_

SS:

SEAL

County of \_\_\_\_\_

Before me the undersigned, a Notary Public for \_\_\_\_\_ County, State of \_\_\_\_\_, personally  
Officer's county of residence Officer's state of residence

appeared \_\_\_\_\_ and he/she, being first duly sworn by me upon his/her oath, say that the  
Name of person

facts alleged in the foregoing instrument are true.

Signed and sealed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
 Signature

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
 Name of officer *(printed or typed)*

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3. Direct questions to Customer Service, Toll-free at (888) 526-1687, Monday – Friday, 8 a.m.- 8 p.m. EST. The agency is closed on weekends and State-approved holidays.

**IMPORTANT INFORMATION**

6. The member must complete the information requested in this affidavit and provide this completed affidavit and the [Attending Physician's Statement for a Classroom Disability Benefit \(State Form 17296\)](#) to the member's attending physician.
7. In compliance with Health Information Portability and Accountability Act (HIPAA) regulations, this form cannot be faxed or e-mailed because of the personal health information (PHI) contained in the document.
8. The member's attending physician must submit this completed affidavit and the completed *Attending Physician's Statement for a Classroom Disability Benefit* (State Form 17296) to the Fund physician appointed by the INPRS Board of Trustees.
9. The Fund physician reviews the documents and makes a determination that is then provided to the INPRS, Teachers' Retirement Fund (TRF).
10. TRF notifies the member of the determination.

| Entry field   | Field description   |
|---|---|
| <b>MEMBER INFORMATION</b>   |   |
| This section is completed by the member with personal and contact information.  |   |
| Member name   | This is the name of the member requesting the classroom disability benefit.                                   |
| Social Security number  | This is the Social Security number (last 4 digits) of the member requesting the classroom disability benefit. |
| PID number  | This is the member's personal identification (PID) number, formerly the TRF number.                           |
| Address   | This is the street or mailing address of the member.  |
| Date of birth   | This is the member' date of birth; format = mm/dd/yyyy.   |
| Telephone number  | This is the member's telephone number with area code.   |
| City, State, ZIP code   | This is the member's city, state, and ZIP Code.   |
| E-mail address  | This is the member's e-mail address.  |
| <b>LAST EMPLOYER INFORMATION</b>  |   |
| This section is completed by the member with contact and employment information about the last employer.  |   |
| Last employer   | This is the name of the member's last employer (school corporation).  |
| Employer city or township   | This is the location city and/or township of the member's last employer.                                      |
| Employer county   | This is the county location of the member's last employer.  |
| Last date of active teaching service  | This is the last date of active teaching service with the last employer; format = mm/dd/yyyy.                 |
| Last teaching position  | This is the title of the last teaching position with the last employer.                                       |
| Date covered service began  | This is the date the covered service began with the last employer; format = mm/dd/yyyy.                       |
| Member's age at beginning service   | This is the member's age at the beginning of covered service.   |
| President of Board or Trustee of last employer  | This is the name of the board president or trustee for the last employer.                                     |
| Superintendent of last employer   | This is the name of the superintendent for the last employer.   |
| Address of President of Board or Trustee of last employer   | This is the contact address for the board president or trustee for the last employer.                         |
| Address of Superintendent of last employer  | This is the contact address for the superintendent for the last employer.                                     |
| <b>MEDICAL INFORMATION</b>  |   |
| This section is completed by the member with information about medical treatment, doctors, etc. The "you" in this section refers to the member. |   |
| Date medical condition began  | Self-explanatory; format = mm/dd/yyyy.  |
| Date you gave up your teaching position   | Self-explanatory; format = mm/dd/yyyy.  |
| Date you first consulted a physician for this condition   | Self-explanatory; format = mm/dd/yyyy.  |
| Date your last school year ended  | Self-explanatory; format = mm/dd/yyyy.  |
| Date your next school year starts   | Self-explanatory; format = mm/dd/yyyy.  |
| Date a half school year will have elapsed since you quit teaching   | Self-explanatory; format = mm/dd/yyyy.  |
| Time lost during last teaching year because of your condition   | Self-explanatory  |
| Earnings, if any, since you ceased public school work   | Self-explanatory  |

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| Entry field   | Field description                                 |
|---|---|
| Name of attending physician you first consulted for this condition  | Self-explanatory                                  |
| Address of attending physician  | Self-explanatory                                  |
| How did your disability begin?  | Self-explanatory                                  |
| Are you confined to bed?  | Self-explanatory                                  |
| Are you confined to a house?  | Self-explanatory                                  |
| Date confinement, if any, began   | Self-explanatory; format = mm/dd/yyyy.            |
| Do you expect such confinement to continue?   | Self-explanatory                                  |
| Describe, in detail, to what extent you are incapacitated from continuing in the teaching profession.   | Self-explanatory                                  |
| What ailments, diseases, illnesses, disorders, infirmities, disabilities, or injuries have you had in the last five years?  | Self-explanatory                                  |
| Have you ever been an inmate of a hospital, asylum, sanitarium, or health resort of any kind?   | Self-explanatory                                  |
| During the last five years have you received a pension from any source, or benefits from any accident or health insurance company or association?   | Self-explanatory                                  |
| Give name and address of every physician and/or specialist you have consulted during the last three years.  | Self-explanatory                                  |
| Have you made claim to any insurance company for benefits because of your condition?  | Self-explanatory                                  |
| Are you able to appear before the examining physician in Indianapolis?  | Self-explanatory                                  |
| If not, can you appear before an examining physician in your area?  | Self-explanatory                                  |
| <b>MEMBER AFFIDAVIT</b>   |   |
| The member must sign and date this document for it to be processed and the member to be considered for the classroom disability benefit.  |   |
| Member's signature  | This form must be signed and dated by the member. |
| Member's name   | This is the member's printed name.                |
| Date  | This form must be signed and dated by the member. |
| <b>NOTARY PUBLIC CERTIFICATION</b>  |   |
| This form must be notarized before it can be processed by INPRS, TRF. Take the form to a Notary Public with an active commission. The Notary will require that you swear or affirm that you are the named person on the form. You will be required to sign and date the form in the Notary's presence. The notary must then complete the NOTARY PUBLIC CERTIFICATION section of the form and affix the Notary's seal. |   |