

# REQUEST FOR ADMINISTRATIVE HEARING

*This is a Request for an Administrative Hearing on a Disability Benefit Determination filed pursuant to the OCERS Administrative Review and Hearing Policy (Disability and Non-Disability Benefits) applicable to Requests for Administrative Hearings filed on or after June 1, 2023.*

**Denial of Disability Retirement Application**. If you are requesting an administrative hearing in connection with the *denial* of a disability retirement application (in whole or in part, including the denial of service connection or the effective date), you must file this request ***no later than*** ninety (90) days from the date that OCERS provides you with notice of the Disability Committee’s recommendation.

**Grant of Disability Retirement Application (Employers Only)**. If you are the Employer requesting an administrative hearing in connection with the *grant* of a disability retirement application in full, including the granting of service connection or the effective date), you must file this request ***no later than*** ten (10) days from the date that OCERS provides you with notice of the Disability Committee’s recommendation.

# Instructions:

1. Complete the “Request for Administrative Hearing” form.
   1. The Clerk will complete Section 1.
   2. Complete Section 3 only if Applicant ***is not*** the OCERS Member whose benefits are at issue.
   3. Complete Section 4 only if you ***are*** the attorney for the Applicant.
   4. The Applicant *or* the Applicant’s attorney must sign and date Section 7.
   5. The OCERS Member must sign and date the Authorization for Use and Disclosure of Protected Health Information.
2. File this form by sending it via e-mail to ***hearings@ocers.org (Preferred)*** or mailing it to:

Orange County Employees Retirement System (OCERS)

Attn: Clerk of the Hearing Officers P.O. Box 1229 Santa Ana, CA 92702

**BEFORE THE BOARD OF RETIREMENT OF THE ORANGE COUNTY EMPLOYEES RETIREMENT SYSTEM**

**Section 1. To Be Completed by the Clerk**

|  |  |
| --- | --- |
| In the Matter of the Application for Disability Retirement of:  , Applicant. | Case No.:  **REQUEST FOR ADMINISTRATIVE HEARING** |

***This is a Request for Administrative Hearing on a Disability Retirement Application. This for is not permissible for use in an appeal of a CEO benefit determination.***

# Section 2. Applicant’s Information

Applicant is:

OCERS Member

[ ]

Filing on behalf of an OCERS Member OCERS Employer

[ ]

[ ]

Other person with interest in an OCERS Member’s pension (e.g., heir, beneficiary, spouse) Name:

[ ]

Address:

Telephone Number:

E-Mail Address:

***[ ] Check here if Applicant consents to have all documents served via e-mail.***

**If Applicant is an OCERS Member, are you/they:**

[ ] Receiving a Service Retirement Benefit

[ ] Receiving a Non-Service Connected Disability Retirement

[ ] Active

# Section 3. OCERS Member Information (complete *only* if the Applicant is not the OCERS Member)

Member Name:

Member’s Address (if known):

Member’s Telephone Number:

Member’s E-Mail Address:

# Section 4. Attorney Information (complete *only* if Applicant is represented by an Attorney)

Name:

California State Bar Number:

Firm Name:

Address:

Phone Number:

E-Mail Address:

# Section 5. Reason for Appeal:

Applicant is contesting (check all that apply): Finding on permanent incapacity Finding on service connection Effective Date

[ ]

[ ]

[ ]

Timeliness of application

[ ]

Date of Disability Committee Meeting:

# Section 6. Details of Appeal

Provide a short description of your claim(s) and why the Disability Committee’s recommendation should be reversed (attach extra pages if necessary). Be as specific as possible. *(****PLEASE NOTE:*** *Pursuant to Rule 3.E.4 of OCERS Administrative Review and Hearing Policy, if at any time during the hearing process (including within this Request for Administrative Hearing), the Applicant alleges an injury or illness that was not presented to the Disability Committee, the Hearing process will be suspended, and the Application will be treated as an amended Application and referred back to OCERS staff to be reevaluated.*)

[Grab your reader’s attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.]

[Grab your reader’s attention with a great quote from the document or use this space to emphasize a key point. To place this text box anywhere on the page, just drag it.]

# Section 7. Signature

Date:

Applicant

Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s Attorney (If represented)

*\*This form and the attached authorization will not be accepted unless both have been signed and dated by the Applicant or Applicant’s Attorney. The Applicant and only the Applicant must sign the authorization. Electronic signature is acceptable.*

**AUTHORIZATION FOR DISCLOSURE AND USE OF PROTECTED HEALTH INFORMATION**

*Completion of this document authorizes the disclosure and/or use of individually identifiable health information* as *set forth below, consistent with California end Federal law concerning the privacy of such Information. Failure to provide all information requested may invalidate this Authorization.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1.Member  Information: | Last Name | First Name | M.I. | SSN (Last 4):  *XXX-XX·* - - - - |

1. **Information Release:** I hereby give my consent and authorization to the release and disclosure of my protected health information, including any and all health and/or medical related information about me in the possession of any health care provider, health plan, insurance company or fund, employer or plan administrator, government agency, organization or entity administering a benefit program, or rehabilitation organization or program and any and all workers' compensation records and all health Information pertaining to my medical history, mental or physical condition and treatment received which Includes but Is not limited to medical histories, diagnoses, examination reports, chart notes, testing and test results, x­ rays, operative reports, lab and medication records, prescriptions, and any other records relating to the prognosis, treatment or diagnosis of any physical, mental, psychological or psychiatric condition, Including drug/alcohol and/or HIV/AIDS to the Board of Retirement Law of 1937 (CERL) (Gov. Code §31450, et. Seq.).

I also authorize the disclosure of any and all personnel and other employment-related records on file with any of my present or former employers which reflect my job duties, work performance, and other work­ related Issues including, but not limited to attendance and sick leave records and records of administrative and judicial action arising out of, or related to, my past or present employment, statements made by other employees regarding or pertaining to the cause of my disability, and physical examinations In connection with employment applications and any and all records subject to the provisions of California Welfare & Institutions Code Sections 11878 and 11879.

1. **Restrictions:** California law prohibits the requester, OCERS, from making further disclosure of my protected health Information unless the requester obtains another authorization from me or unless such disclosure is specifically required or permitted by law. I understand that any information about me disclosed pursuant to this Authorization will be used by OCERS for the administration of Its duties under the CERL. My health information and/or workers' compensation information will be used solely for the purpose of determining my eligibility for OCERS disability retirement benefits.

I understand that by virtue of my application for a disability retirement my protected medical information may be revealed to others, as needed, and may **be** discussed at a public meeting and become public record subject to disclosure under the Public Records Act and/or the Brown Act. I understand that if my protected health Information is disclosed to someone who Is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

1. **My Rights:** I may refuse to sign this authorization; however, I understand that I have the burden of proving by a preponderance of the evidence that I am disabled and where applicable that the disability was service connected. I understand that submission of the requested Information Is mandatory under Government Code § 31723 and that failure to supply the Information requested may result in OCERS being unable to make a determination regarding my status.

*I may inspect or obtain a copy of the protected health information that I am being asked to disclose. I have a right to receive a copy of this authorization.*

Applicant Initials\_\_\_

I may revoke this authorization at any time. My revocation must be In writing, signed by me or on my behalf, and delivered to OCERS at the address above. My revocation will be effective upon receipt. I am aware that my revocation Is not effective to the extent that persons I have authorized to use and/or disclose my protected health Information have acted In reliance upon this authorization. Unless cancelled by me In writing, this Authorization shall be valid for two years from the date of signature hereon. A photographic copy of this Authorization shall be valid as the original.

1. **Member Authorization**:

*I have read the above and I fully understand that my authorization of this Information release will permit OCERS to inspect,* ***review*** *and copy any of all of the records listed above, for a period of two (2) years from the date of the signature hereon.*

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Applicant Signature Date