EMPLOYER STATEMENT—DISABILITY CLAIM

IMRF Form 5.41 (Rev. 02/2013)

Instructions for Employer:

By furnishing this information, you make NO representation regarding the validity of the member's claim for disability benefits.

1. Complete this form:
   a. **As soon as** the member has stopped working and is expected to remain disabled for thirty (30) days or more.
   b. Whether the disabling condition is work-related or not.
2. "Last date the member actually worked" refers to the last day the member was physically present at his or her job. This does not include sick or vacation time.
3. "Last date the member was or will be paid" refers to the last day for which the member will receive wages (or compensation), including sick and vacation time.
4. The Authorized Agent's signature is required for all claims.
5. Print the **member's Social Security Number (or IMRF Member ID, if known)** on all documents you enclose with this form.
6. Do not return this Instruction sheet; **return the form only.**

Disability benefit payments can be reduced or terminated if the member:

- Receives **wages (or compensation)** in any month he or she is disabled.
- **Resigns.** Please refer to the IMRF Authorized Agent Manual, Section 5.40D(5), "Resignations of Disabled IMRF Members."
  - If the member resigns, forward a copy of the resignation letter and supporting documents. **Include meeting minutes** accepting the resignation.

NOTE: Please provide complete and accurate information.
Incomplete or inaccurate information may delay claims processing.

Illinois Municipal Retirement Fund
2211 York Road Suite 500 Oak Brook Illinois 60523-2337
Member Services Representatives 1-800-ASK-IMRF (1-800-275-4673) Fax: (630) 706-4289
www.imrf.org

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Please Print (Use Black Ink)

Please provide complete and accurate information. ***Incomplete or inaccurate information may delay claims processing.***

EMPLOYER NAME	EMPLOYER IMRF ID NUMBER

MEMBER'S NAME	SOCIAL SECURITY NUMBER (*OR IMRF MEMBER ID, IF KNOWN*)
DATE OF BIRTH (MM/DD/YYYY)	OCCUPATION (*ATTACH COPY OF JOB DESCRIPTION*)
Last date member actually worked (MM/DD/YYYY) *(**Not** including Sick or Vacation days.)* _____	Last date member was/will be paid wages or compensation (MM/DD/YYYY) *(Including Vacation Pay, Sick Pay, etc.)* **NOT the date of the member's paycheck.** _____

Within the past 6 months, has the member been off work for the same injury or illness? ..... ☐ No ☐ Yes

TO BE COMPLETED FOR MEMBERS WITH *LESS THAN FIVE YEARS OF IMRF SERVICE CREDIT*

Did the member undergo a pre-employment medical examination? ..... ☐ No ☐ Yes

*(If yes, attach a copy of doctor's report to this form and **print** the member's **Social Security number or IMRF Member ID, if known** on the report)*

Is the member an **Elected Official**? ..... ☐ No ☐ Yes

If yes, does the member participate in the **ECO Plan** ..... ☐ No ☐ Yes

(If yes, complete "To be completed for ECO Members Only" below)

TO BE COMPLETED FOR ECO MEMBERS ONLY

Please enter the dates for the ECO member's term of office ..... _____ _____

If the member is not currently in office, provide dates for LAST elected county office held **FROM** (MM/DD/YYYY) **TO** (MM/DD/YYYY)

Please enter the member's final annual salary earned as a member of the ECO Plan . . . . . .$ _____

Please enter the member's annual stipend(s) as a member of the ECO Plan . . . . . .$ _____

Is the member a **seasonal employee** ..... ☐ No ☐ Yes

If yes, did the member elect to be paid over 12 months? ..... ☐ No ☐ Yes

Has the member **returned to work**? ..... ☐ No ☐ Yes

If yes, please indicate the date (MM/DD/YYYY) _____ and ***attach the Physician's Release.***

If no, give reason: _____

Has the member been **terminated**? ..... ☐ No ☐ Yes

If yes, please indicate the date (MM/DD/YYYY) _____

If yes, give reason: _____

Was a claim made for **workers' compensation or occupational disease benefits**? ..... ☐ No ☐ Yes

If a claim has been made, what is the **status of the claim**: ☐ Approved ☐ Denied ☐ Pending ☐ Appealed

If the claim was approved, what is the weekly benefit amount? $ _____ per week. Benefits start date: _____ (MM/DD/YYYY)

If workers' compensation or occupational disease benefits have ceased, provide **termination date** of benefits: _____ (MM/DD/YYYY)

Name of workers' compensation carrier	Daytime Telephone Number (with Area Code)
Address	City, State and ZIP

Authorized Agent's Signature ***(Required for all claims)***	Date (MM/DD/YYYY)
Daytime Telephone Number. (with Area Code)	Email

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