STATE RETIREMENT SYSTEMS

- State Employees' Retirement System of Illinois
- General Assembly Retirement System
- Judges' Retirement System of Illinois

Internet: *http://www.srs.illinois.gov* E-Mail: *sers@srs.illinois.gov*

2101 South Veterans Parkway, P.O. Box 19255, Springfield, IL 62794-9255

CERTIFICATION OF DISABILITY

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY AND RETURN TO THE ATTENTION OF CLAIMS/DISABILITY.

One requirement for continued eligibility for disability benefits is that any earnings you may have do not exceed the quarterly earnings limitations. The term "earnings limitation" shall be construed to mean any employment by or for the State of Illinois or any remuneration which exceeds $2,490.00 in any calendar quarter. Remuneration shall be defined to mean any compensation for personal services including fees, wages, salary, commissions, and similar items and any income derived from the participation in a business activity through the performance of physical and/or mental activities generally performed for the production of income. Remuneration shall be computed on a gross, rather than net, basis. Remuneration shall also include the fair market value of goods or services received which, if received in money, would otherwise constitute remuneration. The system shall consider the date on which the remuneration was earned, rather than when it was received, and may be earned through either self-employment or employment by others.

Have you exceeded the earnings limitation since your disability began? ☐ YES ☐ NO

If yes, state name and address of employer, salary (monthly, weekly, hourly, etc.)

_____

_____

Have you applied or are you currently receiving a Social Security benefit? ☐ YES ☐ NO

I certify that I am still disabled and I authorize any custodian of medical records or other organizations or persons having any records, data, or information concerning me to furnish such records, data, or information, including records for wage history, benefit information, treatment of a psychiatric condition, AIDS, chemical or alcohol dependence, as may be requested by the State Employees' Retirement System of Illinois. A photocopy of this authorization shall be considered as effective and valid as the original.

I further certify that I will notify SERS if my disability ceases or I become employed.

_____ _____
Signature Date

_____ _____
Phone Number Social Security Number