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 OCCUPATIONAL DISABILITY

In order to verify your continued eligibility for disability benefits through the State Employees' Retirement System (SERS) you must carefully read, fully complete and return the Certification form. Failure to complete and return this form within 30 days of receipt will result in the suspension of your disability benefits and termination of health insurance benefits.

1) Are you currently working? YES ☐ NO ☐

2) Are you currently self employed? YES ☐ NO ☐

3) Have you worked or been self employed while on SERS disability? YES ☐ NO ☐

If you marked yes to questions 1, 2, or 3 you must provide the employer's name, address and phone number.

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____

Earnings limitation - Any member receiving SERS disability benefits who exceeds earnings of $2,490 in any given calendar quarter through any employment including self-employment, is not eligible for SERS disability benefits. Have you exceeded the earnings limitation of $2,490 in any quarter since your SERS disability benefits began?

YES ☐ NO ☐

By initialing the space provided below, I signify that I have fully read and truthfully completed this form. I further understand that pursuant to 40 ILCS 5/1-135, any person who knowingly makes a false statement or falsifies a record in attempt to defraud SERS is guilty of a class 3 felony. If the SERS Board of Trustees has a reasonable suspicion that an attempt has been made to defraud SERS, it is required to report the matter to the appropriate State's Attorney for possible fraud investigation.

Initials: _____

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 SERS. A photocopy of this authorization shall be considered as effective and valid as the original.

By signing below, I certify that I am disabled and the information stated above is correct. I further certify that I will notify SERS if my disability ceases or I become employed.

_____ Signature

_____ Date

_____ E-Mail Address

_____ Phone Number