TEMPORARY
DISABILITY
BENEFIT
APPLICATION
 PACKET
To apply for temporary disability benefits, your initial application for benefits under the Workers’ Compensation Act must be denied and you must have appealed that denial to the Illinois Workers’ Compensation Commission.

You may also apply if you were receiving benefits under the Worker’s Compensation Act and those benefits have been terminated. You need to appeal this termination through Section 19b1 of the Workers’ Compensation Act or through an expedited hearing request. If no decision is reached, you must serve a 150-day waiting period.

**Tier 1** (members hired before January 1, 2011): Temporary disability benefits equal 50% of your final average compensation, or your monthly rate of pay on the date you were removed from payroll, whichever is greater.

**Tier 2** (members hired after December 31, 2010): Temporary disability benefits equal 50% of your final average compensation.
You must be removed from your agency payroll to receive benefits. Termination or resignation from state employment will not affect your eligibility for benefits.

After you receive your first disability payment, the benefit will be paid one month behind and mailed on the 19th of the month, unless the 19th falls on a weekend or holiday. Then the benefit will be paid on the workday prior to the 19th.

Temporary disability benefits are reduced by Social Security disability benefits if you are younger than the full SSA retirement age. If you are the full SSA retirement age or older, your non-occupational disability benefits will be reduced by your SSA retirement annuity.

While you receive your disability benefits, your SERS account will continue to be credited with service and contributions as if you were still working.

Temporary disability benefits are subject to federal income tax, but not state income tax.
You must submit the following required forms to SERS:

- Application for Temporary Benefit
- A photocopy of your birth certificate
- A signed authorization for release of medical information
- The medical form (must be completed by your Physician)
- SSA retirement annuity form if age 65 or older
- SSA disability benefit award letter if receiving SSA disability benefits
- Workers Compensation Employees’ Notice of Injury (CMS 900)

- You must be removed from your agency’s payroll
- You must be found by SERS to be disabled from performing your assigned job duties
- You must serve a 30 day waiting period beginning on your last day paid
- You must apply for benefits within one year from the date of removal from the payroll
- A written request for the temporary disability benefit

*Your agency will be contacted regarding your payroll information and job description. This information can not be submitted by your agency until you have been removed from the payroll.*
NOTE: Additional information is needed before we can process your claim

If you were denied Total Temporary Disability under the Workers’ Compensation Act the following information is needed.

☐ A copy of the initial denial of benefits under the Workers’ Compensation Act.

☐ A copy of the application for adjustment of claim filed with the Illinois Workers’ Compensation Commission.

If you were receiving benefits under the Workers’ Compensation Act and those benefits were terminated, the following information is needed.

☐ A copy of the termination of benefits under the Workers’ Compensation Act.

☐ Copy of the request for a hearing under 19b1 of the Workers’ Compensation Act or a request for an expedited hearing. (Must have WCC stamp on form)

☐ A copy of the decision of the Illinois Workers’ Compensation Commission regarding the 19b1 request or expedited hearing request.

☐ Serve a 150 day waiting period if there is no decision by the Illinois Workers’ Compensation Commission regarding the 19b1 hearing or the expedited hearing request.

Your agency will be contacted regarding payroll information and job description.
OVERPAYMENTS OF TEMPORARY DISABILITY BENEFITS

Temporary disability benefits are paid to you while you are litigating your claim for benefits under the Illinois Workers’ Compensation Act. Once you receive benefits under the Workers’ Compensation Act, the temporary disability benefits are converted to occupational disability benefits. This will usually create an overpayment of benefits.

SERS will need to be reimbursed any overpayment of benefits before additional benefits of any kind can be paid. The overpayment should be sent by you once you received an award or settlement through the Illinois Workers’ Compensation Commission.

Failure to reimburse SERS any overpayment will hold up any additional benefits you may be eligible to receive. If you return to work, the situation could cause an involuntary withholding order against your payroll warrant.

Below is a brief explanation of how an overpayment of temporary disability benefits can be created. (This is an example only)

Employee’s monthly salary: $3,000.00
Monthly SERS temporary disability benefit: $1,500.00 (50 % of salary)
Monthly SERS occupational disability benefits: $2,250.00 (75 % of salary)

Employee received temporary disability benefits 1/1/2007 through 12/31/2007 (12 months)

Through the Illinois Workers’ Compensation Commission, employee received monthly benefits under the Workers’ Compensation Act equaling: $1,999.80
<table>
<thead>
<tr>
<th></th>
<th>SERS temporary disability paid</th>
<th>SERS full occupational disability benefit</th>
<th>workers compensation offset</th>
<th>Net occupational disability benefit that should have been paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-07</td>
<td>$1,500.00</td>
<td>$2,250.00</td>
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<tr>
<td></td>
<td><strong>$18,000.00</strong></td>
<td><strong>$2,250.00</strong></td>
<td></td>
<td><strong>$3,002.40</strong></td>
</tr>
</tbody>
</table>

Total SERS temporary disability benefit paid to employee: $18,000.00  
Net occupational disability that should have been paid: $3,002.40  
Overpayment: $14,997.60

SERS can give an estimate of benefits if an estimated settlement under the Workers’ Compensation Act is received. Have your attorney contact the SERS disability section once a settlement is near.
Temporary Disability Benefits

The SERS temporary disability benefit is available in disputed Workers’ Compensation cases when your claim for benefits under the Workers Compensation Act have been formally denied and an appeal has been filed with the Illinois Workers’ Compensation Commission.

After you receive your first disability check, all future checks are mailed on the 19th of the month, paying you for the previous month. If the 19th falls on the weekend or a state holiday, your check will be mailed on the last working day before the 19th.

You May be Eligible for the SERS Temporary Disability Benefit if:

- You have at least 18 months of credited service with SERS, Teachers’ or State Universities Retirement Systems.
- You file an application within 12 months of the date a disability results in the loss of pay.
- You filed an appeal with the Illinois Workers’ Compensation Commission.
- You submitted the required forms to SERS.
- You have not received, nor had a right to receive, any compensation for at least 30 days.
- SERS finds you to be disabled from performing your assigned job duties.
- OR •

If your Workers’ Compensation benefit is terminated, you may be eligible for the SERS temporary disability benefit if:

- You have at least 18 months of credited service with SERS, Teachers’ or State Universities Retirement Systems.
- You submitted the required forms to SERS.
- You filed an appeal with the Illinois Workers’ Compensation Commission, and requested an emergency hearing through the Workers’ Compensation Commissions’ 19B1 process.
- You served a 150-day waiting period or received a decision from the Illinois Workers’ Compensation Commission on your emergency hearing.
- SERS finds you to be disabled from performing your assigned job duties.

When Payments Begin & End

Your benefit will begin on the 31st day from the date you last received, or had a right to receive, any compensation if your Workers’ Compensation claim was denied.

After your Workers’ Compensation benefit is terminated, the temporary disability benefit will begin the day following termination of your Workers’ Compensation benefits and after the 150-day waiting period, unless a decision has been made on your 19B1 application. Disability benefits for all periods of disability are payable for a total period of time equal to one-half of credited service not earned while on disability, until death, or one of the following events occur:

- Your disability ends.
- You resume gainful employment.
• You reach age 65. (If your disability began after age 60, benefits are payable for five years and are subject to the one-half service credit limitation.)

• A payment is made after determining the state’s liability under the Workers’ Compensation Act or the Workers’ Occupational Diseases Act.

• A final determination is made on the member’s claim by the Illinois Workers’ Compensation Commission.

**IT IS A MEMBER’S RESPONSIBILITY TO NOTIFY SERS IMMEDIATELY IF YOU RESUME GAINFUL EMPLOYMENT OR RECEIVE WORKERS’ COMPENSATION BENEFITS.**

**Disability and Social Security**

You may be eligible for Social Security disability benefits if your disability lasts more than twelve months.

SERS contracts with a firm specializing in assisting members through the Social Security disability application process. If your case is accepted by this firm, they will contact you to begin the application process.

If your case is not accepted, and you remain disabled for more than twelve months, you must apply directly to the Social Security Administration (SSA) for disability benefits. SERS will give you specific directions about the filing process. While your disability claim is reviewed by the SSA, you receive your full SERS benefit.

If your SSA award is retroactive, you may be required to repay SERS the full amount of your award. This lump sum payment must be made from your initial SSA payment. Future increases in Social Security disability benefits will not affect your SERS benefit.

If you are receiving any other SSA benefits, contact SERS immediately. Certain SSA benefits may lead to a larger repayment to SERS. When you reach your full Social Security retirement age, your SERS disability payment will be reduced by the amount of your Social Security pension benefit.

**Investigation of Disability Claims**

After you receive your first disability payment, the Disability Section may contact you by mail to obtain additional information that was not included on your benefit application.

Every January and July a new medical form will be sent to you which must be completed by your physician. An exam is not required if you have seen your physician within the last two months, however the form must be completed and returned to SERS.

Included with the medical form is a Certification of Disability form, and a form certifying that you have not earned more than the calendar quarterly limitation while receiving your SERS disability benefit.

During your disability, you may be contacted regarding your disability, current medical treatment, and other daily activities. You may also be asked to undergo an independent medical examination. Your cooperation is vital to this disability investigation process. Failure to cooperate may result in the termination of your temporary disability benefit.

**Working While Disabled**

You can work outside of state government and earn up to the calendar quarterly limitation without disrupting your disability benefit.

*It is important to remember that you cannot earn more than the calendar quarterly limitation, nor return to work for the State in any capacity.*
If you exceed the calendar quarterly limitation, an overpayment of disability benefits will result, requiring you to repay these benefits. Call the Disability Section at 217-785-7318 if you have questions or need assistance with any aspect of your disability benefit.

**SERS Recovery Rights**
Once the Illinois Workers’ Compensation Commission makes its final determination on a disputed claim, SERS will calculate your benefit to determine if temporary benefits must be repaid. Any member who accepts a temporary benefit acknowledges and authorizes the recovery rights of SERS.

**Important!**
If your injury was caused by a third party (i.e. motorist, contractor, etc.) and you collect money from that party, SERS is entitled to a reimbursement for sums paid to you in occupational disability benefits and service contributions.
REQUIRED SIGNATURE FOR TEMPORARY DISABILITY

Name: ________________________________

SSN: ________________________________

I have read the information regarding temporary benefits. I understand that this benefit is temporary until I receive benefits under the Workers’ Compensation Act (WCA). I understand that once I receive benefits under the WCA, my temporary disability benefits from the State Employees’ Retirement System (SERS) will be converted to occupational disability benefits.

This conversion will create an overpayment of temporary disability benefits which I am responsible to repay to SERS. If additional disability benefits are due to me after I receive benefits under the WCA, I understand that I must repay the overpayment before I can receive the additional benefits.

I understand that if I am currently receiving a disability benefit or am eligible for an unreduced retirement benefit from Social Security, my SERS temporary disability benefit will be reduced by the required offset.

I understand that if I am receiving an unreduced retirement benefit (full retirement age) from Social Security, I must notify SERS. In the event that my injury was caused by a third party and I collect an award from that party, I understand that SERS is entitled to be reimbursed for sums paid to me in occupational disability benefits and service contributions.

With consideration of the above information, I request temporary benefits from SERS and agree to repay any overpayment once I receive benefits under the WCA.

Signature ____________________________

Date ________________________________
APPLICATION FOR TEMPORARY DISABILITY BENEFITS

Complete the following if there is no label or the label is incorrect!


Social Security Number

First Name        Middle        Last

Street Address (Permanent Mailing Address)

City        State        Zip Code

You are required to submit a copy of the Workers' Compensation Employees' Notice of Injury (CMS900) with this application for Temporary Disability Benefits.

1. Telephone Number: (home)________________________(work)________________________

2. Title of your position __________________________

3. Was this disability work related? (If yes, you must file for Workers Compensation benefits) □ YES □ NO

4. Have you filed a claim for Workers' Compensation for this disability? □ YES □ NO

5. Has Workers' Compensation □ denied your request or □ terminated your benefit.

6. Date of injury or accident __________________________ 7. Date you ceased work __________________________

8. Have you been removed from your agency payroll? □ YES □ NO

9. Have you returned to work? □ YES □ NO

10. Date you returned to work __________________________ 11. Date you expect to return to work __________________________

12. Did a third party (other than your employer) cause this accident? □ YES □ NO

13. If you answered yes to #12, is a lawsuit being filed against that party? □ YES □ NO

14. Describe accident or illness that caused disability: _______________________________________________________

_____________________________________________________________________________________________________

15. Have you applied for any type of Social Security Benefit? □ YES □ NO

16. Are you currently receiving a Social Security Benefit? □ YES □ NO If yes indicate benefit type ___________________

17. Name and complete address of physicians who have treated you for this disability: ____________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

- OVER -
18. Name and address of hospital to which you were confined for this disability: ____________________________________
______________________________________________________________________________________________

19. Dates you were confined to hospital, from: __________________________ to _________________________

20. Have you ever been a member of the State Universities Retirement System of Illinois? ☐ YES ☐ NO

21. Have you ever been a member of the Teachers' Retirement System of Illinois? ☐ YES ☐ NO

22. Temporary disability benefit is subject to federal income tax withholding in accordance with Federal Withholding Tables, unless you elect not to have taxes withheld. These benefits are exempt from Illinois income tax. As part of the application process for these benefits you need to complete the income tax withholding that appears below.

You may elect not to have withholding taken, or to have withholding taken at any level. If you do not indicate a preference for withholding, SERS must withhold at the rate for a married person with three exemptions. You may change your withholding or discontinue withholding at any time.

Occupational disability benefits paid by SERS are exempt from federal and Illinois income tax. Although exempt, these benefits are reportable and a 1099-R form will be issued each January. If you are requesting occupational disability benefits you do not need to complete the withholding form that appears below.

Federal Income Tax Withholding for Disability Payments

1) I elect not to have income tax withheld from my disability benefit. (Do not complete line 2 or 3.)

2) I want my withholding from each periodic disability payment to be figured using the number of allowances and marital status shown. (You may also designate an additional dollar amount on line 3.)

   Marital Status: ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate

3) I want the following additional amount withheld from each disability payment. Note: For periodic payments, you cannot enter an amount here without entering the number (including zero) of allowances on line 2

   $________________________

23. I hereby certify that I have not been gainfully employed during the time I am claiming disability. I will notify the State Employees’ Retirement System immediately when my disability ceases; or when I return to state employment; or when I accept other gainful employment. I authorize the State Employees’ Retirement System to apply any future disability benefits, pension benefits, death benefits or refund of contributions to any excess disability benefit I may have received until the excess disability benefit is repaid in full. I also agree that if this disability is for occupational reasons, I authorize the State Employees’ Retirement System to exchange information with the appropriate agency handling workers’ compensation relative to my claim and with physicians performing independent medical consultations. Further, I authorize the State Employees’ Retirement System to have an agent or representative review my file for the purpose of evaluating the likelihood of my qualifying for social security disability benefits, which agent or representative may contact me concerning the filing of such a claim. I also agree to permit the State Employees’ Retirement System to furnish medical documentation to the Department of Personnel for the purpose of documenting my leave status. In the event that my injury was caused by a third party and a lawsuit is filed (and I collect an award from that party), I understand that the State Employees’ Retirement System is entitled to be reimbursed for sums paid to me in Temporary Disability Benefits and service contributions.

24. I certify this information is correct. I am aware that pursuant to the 40 ILCS 5/1-135 any person who knowingly makes a false statement or falsifies a record in an attempt to defraud the State Employees’ Retirement System 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 investigation.

___________________________________________________
Signature

Date

Note: If this application is not returned within the 12 months from the date you were removed from the payroll, it could result in a loss of benefits.
RELEASE OF INFORMATION AUTHORIZATION

I authorize any physician, hospital, insurer, the Social Security Administration or another organization having any records, data or information concerning me to furnish such records, data or information to the State Employees’ Retirement System of Illinois.

The type of information to be disclosed includes the patient’s entire medical record, employment record (including salary postings), or a record of all benefit payments.

I understand that the information being disclosed may include information relating to sexually transmitted disease, acquire immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse and generic health information from medical records.

The information for which I am authorizing disclosure will be used for establishing eligibility for disability benefits from the State Employees’ Retirement System.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

This authorization will expire 12 months from the date of signature listed below, unless otherwise revoked.

I understand that once the above information is received, it may be disclosed by the recipient pursuant to evaluating my continued eligibility for disability benefits, and may no longer be protected by federal privacy regulations. The State Employees' Retirement System is not liable for any consequences of such re-disclosure.

I understand that authorizing the use or disclosure of the information identified is mandatory to establish my eligibility for disability benefits.

Name: ________________________________________ (Please Print)

Address: ______________________________________

City: __________________________ State: __________ Zip: ______________

Phone: __________________________

Social Security Number: ______________ Date of Birth: ______________

Signature: __________________________ Date of Signature: ______________

Witness: __________________________ Date of Signature: ______________
Work-related Accidents Not Caused by Your Employer

If your work-related accident was caused by a person other than your employer and you receive benefits from the State Employees' Retirement System (SERS), State law provides that SERS shall be entitled to collect a portion of any settlement you receive from the responsible party and/or their insurance.

You must notify SERS if you are receiving occupational disability benefits and you file a lawsuit against a third party. Failure to notify SERS of filing a lawsuit against a third party may be considered an attempt to defraud SERS and could result in the termination of your disability benefits.

If you have any questions regarding your obligation to notify SERS when filing a lawsuit against a third party, you may contact Don Williams, SERS Disability Supervisor, at (217) 785-7262.
TEMPORARY DISABILITY MEDICAL REPORT

DEAR DOCTOR:

The employee named below has made application for disability benefits from the State Employees' Retirement System. Please complete and return this form to the above address. \textit{THE EMPLOYEE'S ELIGIBILITY FOR BENEFITS CANNOT BE DETERMINED UNTIL WE RECEIVE THIS INFORMATION.} This form is acceptable only if completed by a licensed Medical Doctor.

\textbf{Employee Name:} [___ ___ ___ ___ ___ ___ ___ ___ ___]
\textbf{S.S.N.:} [___ ___ ___ ___ ___ ___ ___ ___ ___]
\textbf{Date of Birth:} [___ ___ ___ ___ ___ ___ ___ ___ ___]

\textbf{DIAGNOSIS AND CONCURRENT CONDITIONS:}

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

\textbf{PLEASE LIST RESULTS OF APPROPRIATE LABORATORY STUDIES:}

________________________________________________________________________

________________________________________________________________________

\textbf{PLEASE LIST OBJECTIVE SYMPTOMS AND FINDINGS (Please be specific, i.e., B/P reading, or attach a copy of patient's charts):}

________________________________________________________________________

________________________________________________________________________

\textbf{NATURE OF TREATMENT AND DATES: (Enclose your statement if more convenient)}

________________________________________________________________________

________________________________________________________________________

\textbf{HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY MEDICALLY UNABLE TO WORK:}

\textbf{ONSET DATE:} [___ ___ ___ ___ ___ ___ ___ ___ ___], 20___
\textbf{TO:} [___ ___ ___ ___ ___ ___ ___ ___ ___], 20___
\textbf{RETURN TO WORK DATE:} [___ ___ ___ ___ ___ ___ ___ ___ ___], 20___

\textbf{REMARKS:}

________________________________________________________________________

________________________________________________________________________

THE ABOVE NAMED INDIVIDUAL APPEARED BEFORE ME FOR MEDICAL EXAMINATION.
THE DIAGNOSIS, TREATMENT AND REMARKS ARE MY PROFESSIONAL OPINION.

\textbf{PRINTED NAME:} [______________] \hspace{2cm} \textbf{DATE:} [______________]
\textbf{SIGNATURE:} [______________] \hspace{2cm} \textbf{REGISTRATION NUMBER:} [______________]
\textbf{ADDRESS:} [______________] \hspace{2cm} \textbf{TELEPHONE NUMBER:} [______________]

3135 (R-10-07)
DEAR MEMBER:

WE NEED A COPY OF YOUR BIRTH CERTIFICATE TO COMPLETE YOUR MEMBERSHIP RECORD. PLEASE WRITE THE LAST FOUR DIGITS (XXX-XX-1234) OF YOUR SOCIAL SECURITY NUMBER ON YOUR BIRTH CERTIFICATE.

Any person making application for a retirement annuity, survivor’s annuity, temporary disability, non-occupational or occupational disability benefit must submit as proof of birth date, a legal copy of their birth certificate or birth record issued by state/county of birth.

If you DO NOT have a copy of your birth certificate, it will be necessary that you obtain a copy from the state in which you were born.

If NO RECORD EXISTS, you must submit a signed affidavit certifying that no birth record exists. Upon submission by the signed affidavit, the following documents may be submitted for consideration of proof of birth date:

1) Military Records;
2) Marriage record showing date of birth;
3) Evidence of social Security payments that require attainment of specific age;
4) Church record of birth or baptism;
5) Valid Passport;
6) Valid driver’s license; or
7) Two or more documents showing birth dates, such as, Naturalization papers, insurance policies, school records or medical records.

If none of the above documents are available, an affidavit from parents, older sibling, or relative having knowledge of the date of birth may be considered. If you need information on where to write for your birth record, please contact our office at (217)785-7444.

I am aware that pursuant to the 40 ILCS 5/1-135 any person who knowingly makes a false statement or falsifies a record in an attempt to defraud the State Employees’ Retirement System 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 investigation.

3928 (R-09-15)
NOTE: You can work without interrupting your disability benefits as long as you do not exceed the calendar quarterly limitations.

The current calendar quarterly limitations are:

1. Any employment by or for the State of Illinois.
2. Any remuneration (gross income) which exceeds $2,490.00 in any calendar quarter.

If you have any questions, please call the State Employees’ Retirement System Disability Section at 217-785-7318.
It is your responsibility to call the Retirement System’s disability section when you return to work. If you do not call to report your return to work, there will be an overpayment of benefits.

Please call 217-785-7318
SSA BENEFITS AND YOUR SERS DISABILITY

In accordance with the State Employees’ Retirement System (SERS) statutes, the disability benefit you are receiving must be reduced by the initial monthly disability benefit you receive from the Social Security Administration (SSA).

If you receive a retroactive SSA disability award which is for a period you receive SERS disability benefits, or you receive SSA disability benefits without your SERS disability benefit being reduced, there will be an overpayment of SERS disability benefits.

The SERS Disability Section will be in touch with you during the first year of receipt of disability benefits. This contact will be to assist you in filing for SSA disability benefits.

If you are receiving disability benefits or a reduced retirement annuity from the SSA, please contact the Retirement System immediately!
UNREduced SOCIAL SECURITY PENSION ESTIMATE
Only to be completed if you are currently age 65 or greater

PART I (TO BE COMPLETED BY SERS MEMBERS)

I, ____________________________________________ (Name of SERS Member) __________________________ (Social Security Number)

hereby authorize the Social Security Administration to furnish the information requested below to the STATE EMPLOYEES’ RETIREMENT SYSTEM OF ILLINOIS. This information is required in the com-putation of benefits payable to me by the State Employees’ Retirement System.

__________________________________________ (Signature of Claimant)
__________________________________________ (Street)

__________________________________________ (Date) __________________________________________ (City)
__________________________________________ (State) __________________________________________ (Zip Code)

PART II (SOCIAL SECURITY ADMINISTRATION ONLY)

Please complete this form based on the worker’s record for unreduced retirement benefits he/she would be eligible to receive on the date indicated below.

Unreduced Social Security Retirement Benefits
as of ____________________ would be ____________________________ .

Send information to:

STATE EMPLOYEES’ RETIREMENT SYSTEM
2101 South Veterans Parkway
P.O. Box 19255
Springfield, Illinois 62794-9255

__________________________________________ (Signature)

__________________________________________ (Title)

__________________________________________ (District Office)

Date ________________________________

3129 (R-10-10)
IMPORTANT MEMO
PAYROLL DEDUCTIONS FOR OPTIONAL SERVICE CREDIT

If you are purchasing optional service credit through payroll deduction, please note that this deduction will cease while you are off the payroll.

Upon returning to work, it is your responsibility to contact your agency’s payroll officer immediately to set up a “catch up” schedule. One option is to double the payroll deduction for the number of pay periods that deductions were missed.

(Example: 8 deductions of $15.00 missed, agency may deduct $30.00 for 8 deductions)

If the payroll deduction agreement ends before you return to work, you will be billed by SERS for the balance due.

NOTE: DUE TO THE I.R.S. REGULATIONS, THE AGREEMENT DUE DATE CAN NOT BE EXTENDED FOR ANY REASON IF THE PAYMENT IS BEING MADE ON A TAX DEFERRED IRREVOCABLE PAYROLL DEDUCTION BASIS.

3990 (N-11-08)