Employer Statement for Disability Forms

SERS
State Employees' Retirement System

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srs.illinois.gov

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

217-785-7444
Email: sers@srs.illinois.gov

Employer Statement for Disability

1. Type of claim
   - | Occupational disability
   - | Nonoccupational disability
   - | Temporary disability

Member information

Name *(Last, first, middle)* _____

SSN *(last 4)* **or Member ID** _____

Address *(Street, City, State, Zip)* _____

Phone number _____

2. Last day employee physically worked: (MM/DD/YYYY) _____

3 (a). Last day of salary or wages due employee: (MM/DD/YYYY) _____

(b). Date employee removed from payroll, biweekly or either the 15th or the end of month: _____

(c). Has employee returned to work? Yes | No Date returned to work: _____

4 (a). Reason for removal:
- | Medical Leave of Absence
- | Service Connected Leave

(b). Effective date of removal action: (MM/DD/YYYY) _____

5. Number of unused sick days remaining: _____

6 (a). Employee base rate of pay: $_____

(b). Employee work status: | Full time | Part time

(c). Employee total rate of pay: $_____

(d). Pay frequency: monthly semi-monthly | biweekly hourly

7 (a). Has the employee filed a claim for Worker's Compensation benefits? | Yes | No

(b). Was Worker's Compensation claim denied? | Yes | No

8 (a). Is there any indication this is a work-related disability? | Yes | No

(b). If yes, was there a 3rd party involved? | Yes | No

9. Are you aware of any official misconduct charges (pending, dismissed, or finalized) against the member, relating to, arising out of, or in connection with their employment with the state of Illinois? | Yes | No

Retirement Coordinator signature _____ Date _____

Phone number _____

1. Type of claim
   - ☐ Occupational disability
   - ☐ Nonoccupational disability
   - ☐ Temporary disability

2. Last day employee physically worked: (MM/DD/YYYY) _____

3 (a). Last day of salary or wages due employee: (MM/DD/YYYY) _____

(b). Date employee removed from payroll, biweekly or either the 15th or the end of month: _____

(c). Has employee returned to work? Yes No Date returned to work: _____

Please Note

1. Select the type of claim being applied for
2. Input the date when the member was last physically at work

3 (a). When the agency last paid the member

3 (b). 15th, 30th, or 31st

3 (c). Has the employee physically returned to work from the specific injury the member is submitting a claim for?

4 (a). Reason for removal:
Medical Leave of Absence
Service Connected Leave

(b). Effective date of removal action: (MM/DD/YYYY) _____

Please Note

4 (a). Medical Leave of Absence: Nonoccupational Disability Claim

4 (a). Service Connected Leave: Occupational Disability Claim

4 (b). This date is the date the agency takes the action to remove the member from payroll. (If the member is going on an occupational benefit and the agency pays them 5 service connected days then it would be 5 days from the last day worked. Nonoccupational and Temporary claims would not be 5 days from when the member last physically worked.)

5. Number of unused sick days remaining: _____

6 (a). Employee base rate of pay: $_____

(b). Employee work status: Full time Part time

(c). Employee total rate of pay: $_____

(d). Pay frequency: monthly semi-monthly biweekly hourly

7 (a). Has the employee filed a claim for Worker's Compensation benefits? Yes No

(b). Was Worker's Compensation claim denied? Yes No

Please Note

5. For Nonoccupational claims this number needs to be 0

6 (a). Rate of pay at the time of leave for this specific leave, not current rate of pay

6 (b). Full time or Part time

6 (c). Including longevity pay or this will cause a discrepancy

6 (d). Monthly, semi-monthly, biweekly, or hourly

7 (a). Yes or No

7 (b). If the answer if yes, then the member should be applying for Temporary Disability

8 (a). Is there any indication this is a work-related disability? | Yes | No

(b). If yes, was there a 3rd party involved? | Yes | No

9. Are you aware of any official misconduct charges (pending, dismissed, or finalized) against the member, relating to, arising out of, or in connection with their employment with the state of Illinois? | Yes | No

Please Note

8 (a). Yes or No

8 (b). Yes or No

9. This question is asking for felonies at your job against the State of Illinois

Job Duty Statement

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Job Duty Statement

Member information

Name *(Last, first, middle)* _____ **SSN** *(last 4)* **or Member ID** _____

Address *(Street, City, State, Zip)* _____ **Job title** *(no temporary titles)* _____

To be completed by the member's supervisor.

Please indicate, by using the numbers 0-3 in the grading system below, the average daily job demand of the above named member. If lifting is involved, please indicate if the employee must also carry the object. Also, indicate if the employee would have intermittent rest while performing the demand.

Grading system

0 - Never 1 - Monthly 2 - Weekly 3 - Daily

Please complete section below based on actual job duties employee is required to perform.

1. _____ Working on or with moving machinery (☐ with ☐ without intermittent rest)
2. _____ Working on or with moving machinery using foot controls (☐ with ☐ without intermittent rest)
3. _____ Driving automotive equipment, including loading & unloading (☐ with ☐ without intermittent rest)
4. _____ Driving automotive equipment (☐ with ☐ without intermittent rest)
5. _____ Lifting 1-10 lbs (☐ with ☐ without carrying) (☐ with ☐ without intermittent rest) (☐ with ☐ without help available)
6. _____ Lifting 11-25 lbs (☐ with ☐ without carrying) (☐ with ☐ without intermittent rest) (☐ with ☐ without help available)
7. _____ Lifting 26-50 lbs (☐ with ☐ without carrying) (☐ with ☐ without intermittent rest) (☐ with ☐ without help available)
8. _____ Lifting 51-100 lbs (☐ with ☐ without carrying) (☐ with ☐ without intermittent rest) (☐ with ☐ without help available)
9. _____ Pushing and hand trucking (weight _____) (number of times per day _____) (☐ with ☐ without intermittent rest)
10. _____ Climbing stairs (☐ with ☐ without intermittent rest)
11. _____ Climbing ladders (☐ with ☐ without intermittent rest)
12. _____ Walking (☐ with ☐ without intermittent rest)
13. _____ Standing (☐ with ☐ without intermittent rest)
14. _____ Sitting
15. _____ Running
16. _____ Bending or stooping (☐ with ☐ without intermittent rest)
17. _____ Reaching above shoulder level (☐ with ☐ without intermittent rest)
18. _____ Use of hands for gross manipulation (grasping, twisting, handling)
19. _____ Use of hands for fine manipulation (typing, good finger dexterity)
20. _____ Wet work- (☐ hands ☐ feet)
21. _____ Dust, fumes, gases - (☐ respiratory irritants ☐ skin irritants ☐ allergic irritants)
22. _____ Use of a weapon
23. _____ Dealing with combative individuals
24. _____ Maintain an appropriate work pace
25. _____ Perform complex or varied tasks
26. _____ Relate to others (co-workers and /or public)
27. _____ Make critical decisions
28. _____ Manage or supervise projects or staff
29. _____ Interact with public or co-workers in written form
30. _____ Other/comments (use back of form if necessary to describe any job demands unique to this employee's duties)

Supervisor signature _____ **Date** _____

Agency name/address _____ **Phone** _____

Please complete section below based on actual job duties employee is required to perform.

1. _____ Working on or with moving machinery (☐ with ☐ without intermittent rest)
2. _____ Working on or with moving machinery using foot controls (☐ with ☐ without intermittent rest)
3. _____ Driving automotive equipment, including loading & unloading (☐ with ☐ without intermittent rest)
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Claim Notification (Disability)

Member information

Name *(Last, first, middle)*

SSN *(last 4)* or Member ID

Address *(Street, City, State, Zip)*

Phone number
(H)
(W)
(C)

Email address

Agency information

Agency name

RC phone number

Retirement Coordinator (RC) signature

Date

Member Tier
☐ Tier 1 ☐ Tier 2

Claim information

If employee had WC claim denied OR if TTD benefits stopped. Complete section below for temporary disability only.

Nonoccupational disability

Date last worked

Date leave of absence begins

Maternity? ☐ Yes ☐ No

Occupational disability

Date of accident

Date removed from payroll

Temporary disability *(if WC claim denied or TTD ended)*

Date last worked

Date last paid

Did employee have WC claim denied? ☐ Yes ☐ No

Did TTD payments stop? ☐ Yes ☐ No

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Claim Notification (Disability)

Member information

Name *(Last, first, middle)*

SSN *(last 4)* or Member ID

Address *(Street, City, State, Zip)*

Phone number
(H)
(W)
(C)

Email address

Agency information

Agency name

RC phone number

Retirement Coordinator (RC) signature

Date

Member Tier
☐ Tier 1 ☐ Tier 2

Claim information

If employee had WC claim denied OR if TTD benefits stopped. Complete section below for temporary disability only.

Nonoccupational disability

Date last worked _____ Date leave of absence begins _____

Maternity? ☐ Yes ☐ No

Occupational disability

Date of accident _____ Date removed from payroll _____

Temporary disability *(if WC claim denied or TTD ended)*

Date last worked _____ Date last paid _____

Did employee have WC claim denied? ☐ Yes ☐ No Did TTD payments stop? ☐ Yes ☐ No

Comments:

Please Note

In Regards to Disability Claims

- Your agency should never put a member back on payroll when they are on a disability benefit
- Returning to payroll is not the same as physically returning to work.