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## 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 or finalized) against the member, arising from or in connection with their employment with the state of Illinois?  Yes  No

Retirement Coordinator signature \_\_\_\_\_ Date \_\_\_\_\_

Phone number \_\_\_\_\_

# Instructions for Completing Employer Statement for Disability

1. (a) Type of claim – Complete by checking appropriate box for type of claim received.  
(b) Workers Compensation was denied you must mark the type of claim as Temporary disability
2. (a) Last date employee worked – Indicate the last date that the employee was present and worked.
3. (a) Last day salary or wages due employee – Indicate the last day employee earned normal pay. In the case of medical leave of absence, indicate the last day employee earned pay (could be sick or vacation pay).  
(b) Date employee removed from payroll – Indicate the pay period ending date of when employee was removed from payroll.  
(c) Has employee returned to work? – Complete by checking the appropriate box. If yes, indicate the physical return to work date.
4. (a) Reason for removal – Complete this section by checking the appropriate box.  
(b) Indicate the effective date of the removal. The effective date of action is the actual date of event.
5. (a) Unused sick days – Complete this section by indicating the number of unused sick days for the specific time period.  
(b) If the type of claim is Temporary or Occupational - the member is not required to use sick time  
(c) If the type of claim is Nonoccupational - all sick time must be exhausted before the benefit can be paid
6. (a) Employee base rate of pay - Indicate base rate of pay.  
(b) Employee work status - Complete by checking appropriate box.  
(c) Employee's total rate of pay includes base rate of pay plus, longevity, bilingual and permanent differential.  
(d) Frequency of Pay - Complete by checking appropriate box.
7. (a) Filed claim for Workers Compensation? - Complete by checking appropriate box  
(b) Worker's Compensation denied - Complete by checking appropriate box
8. (a) Is there any indication that this is a work-related disability? Complete by checking the appropriate box.  
(b) If this is a work related disability, was a 3rd party involved? Complete by checking the appropriate box.

**The Agency Retirement Coordinator is required to sign, date and list their phone number in case State Retirement System has questions. Agencies should not pay out any benefit time while a member is on a disability benefit.**