DISABILITY

Rev. 11-15-04

Eligibility

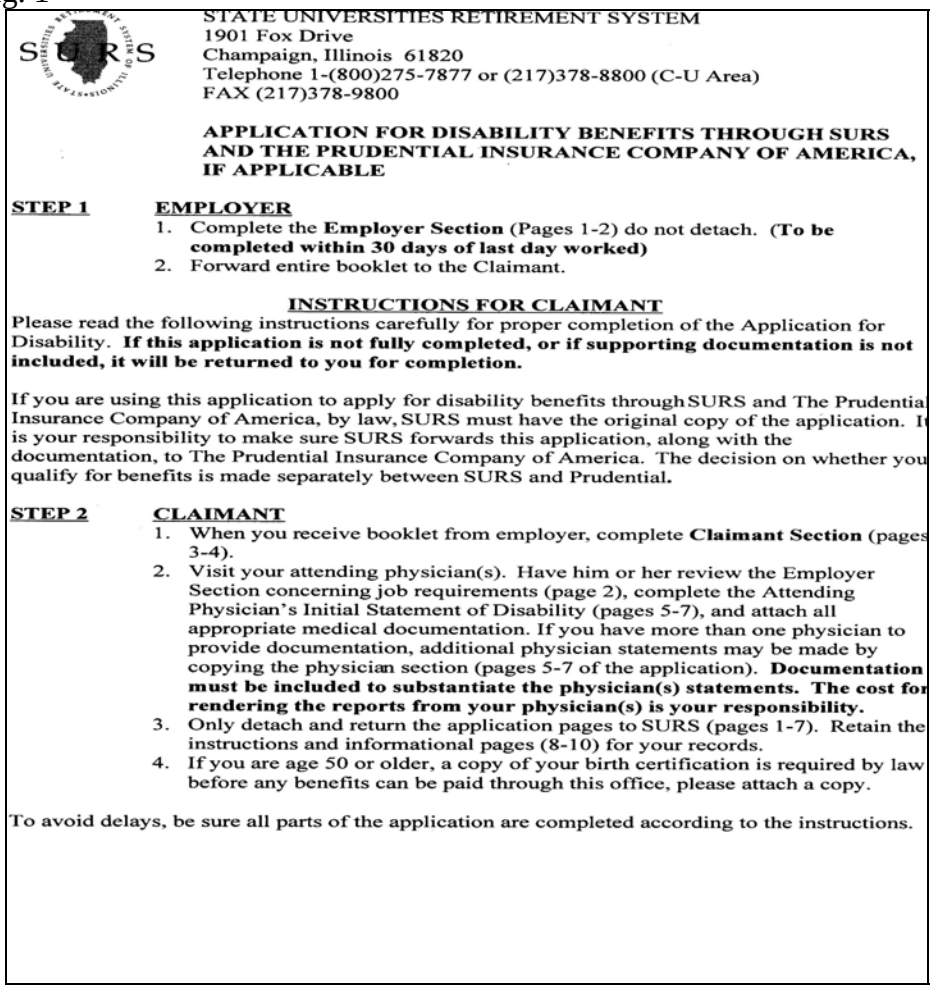
An Employee is eligible to apply for a disability if he or she: (1) becomes physically or mentally incapacitated and unable to perform the duties of his or her assigned position for over 60 days and (2) had completed 2 years of service at the time of disability, unless the disability is the result of an accident.

Once eligibility has been determined, the employee must request an Application for Disability from the employer. This form should be filled out and submitted **immediately**, unless it is certain that the disability will be less than 60 days.

The benefit cannot begin more than 30 days before the date SURS receives the application, unless the Board of Trustees determines there was good cause for missing the filing deadline.

The first page of the disability application includes directions for completing the application process (Fig.1).

Fig. 1



STATE UNIVERSITIES RETIREMENT SYSTEM
1901 Fox Drive
Champaign, Illinois 61820
Telephone 1-(800)275-7877 or (217)378-8800 (C-U Area)
FAX (217)378-9800

APPLICATION FOR DISABILITY BENEFITS THROUGH SURS AND THE PRUDENTIAL INSURANCE COMPANY OF AMERICA, IF APPLICABLE

STEP 1 **EMPLOYER**

1. Complete the **Employer Section** (Pages 1-2) do not detach. **(To be completed within 30 days of last day worked)**
2. Forward entire booklet to the Claimant.

INSTRUCTIONS FOR CLAIMANT

Please read the following instructions carefully for proper completion of the Application for Disability. **If this application is not fully completed, or if supporting documentation is not included, it will be returned to you for completion.**

If you are using this application to apply for disability benefits through SURS and The Prudential Insurance Company of America, by law, SURS must have the original copy of the application. It is your responsibility to make sure SURS forwards this application, along with the documentation, to The Prudential Insurance Company of America. The decision on whether you qualify for benefits is made separately between SURS and Prudential.

STEP 2 **CLAIMANT**

1. When you receive booklet from employer, complete **Claimant Section** (pages 3-4).
2. Visit your attending physician(s). Have him or her review the Employer Section concerning job requirements (page 2), complete the Attending Physician's Initial Statement of Disability (pages 5-7), and attach all appropriate medical documentation. If you have more than one physician to provide documentation, additional physician statements may be made by copying the physician section (pages 5-7 of the application). **Documentation must be included to substantiate the physician(s) statements. The cost for rendering the reports from your physician(s) is your responsibility.**
3. Only detach and return the application pages to SURS (pages 1-7). Retain the instructions and informational pages (8-10) for your records.
4. If you are age 50 or older, a copy of your birth certification is required by law before any benefits can be paid through this office, please attach a copy.

To avoid delays, be sure all parts of the application are completed according to the instructions.

Employer Responsibilities

Forms Required

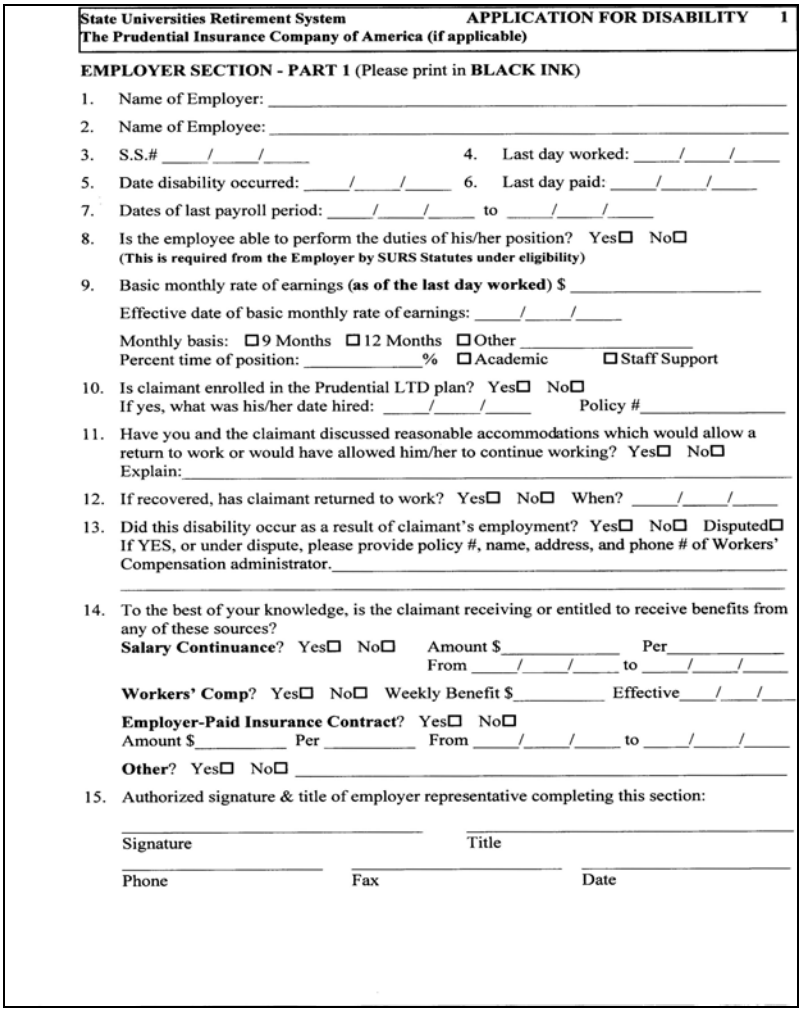
1. Application for Disability (Employer Section; 2 pages)
2. Employer Summary Request Report (2 pages)

Application for Disability

SURS will send each employer/agency a supply of Disability Applications. The disabled employee will request this application from his or her employer.

The employer must fill out the Employer Section of the application (Figs. 2 and 3). If it is filled out completely and correctly, without any estimated dates, SURS will not require any additional documents from the employer in order to process the claim.

Fig. 2



State Universities Retirement System **APPLICATION FOR DISABILITY** 1
The Prudential Insurance Company of America (if applicable)

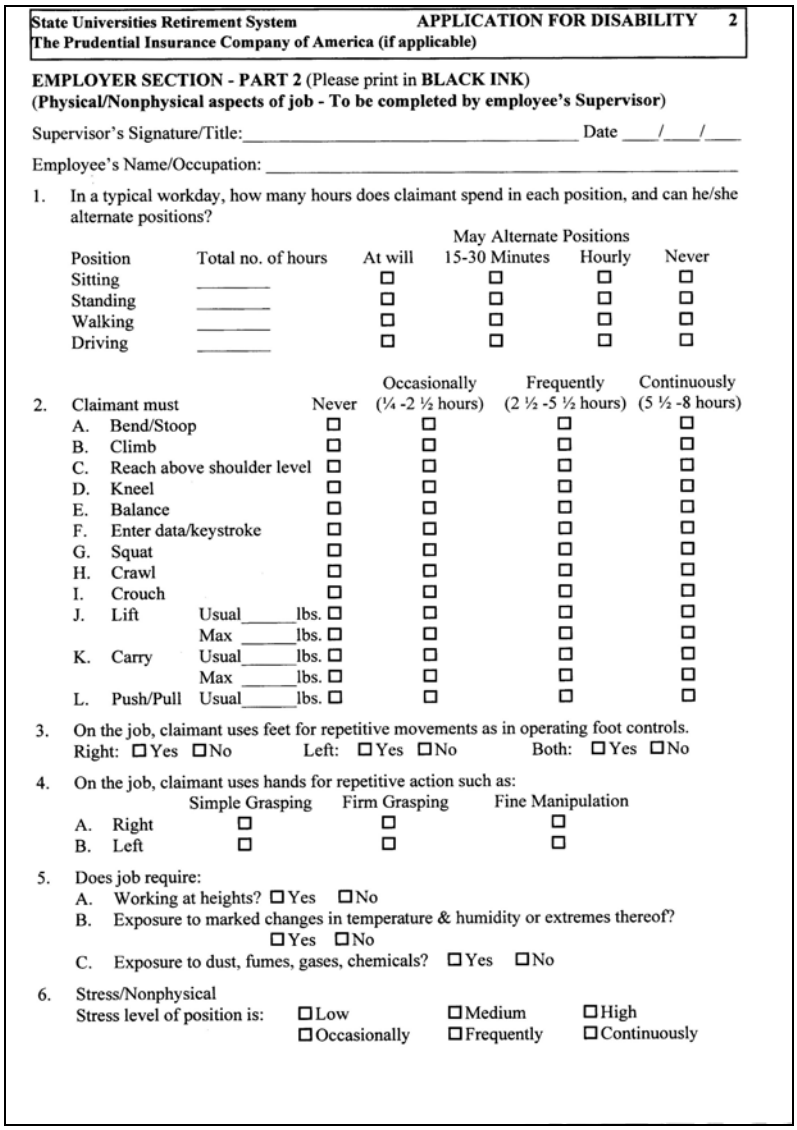
EMPLOYER SECTION - PART 1 (Please print in **BLACK INK**)

1. Name of Employer: _____
2. Name of Employee: _____
3. S.S.# _____/_____/_____ 4. Last day worked: _____/_____/_____
5. Date disability occurred: _____/_____/_____ 6. Last day paid: _____/_____/_____
7. Dates of last payroll period: _____/_____/_____ to _____/_____/_____
8. Is the employee able to perform the duties of his/her position? Yes☐ No☐
   (This is required from the Employer by SURS Statutes under eligibility)
9. Basic monthly rate of earnings **(as of the last day worked)** $ _____
   Effective date of basic monthly rate of earnings: _____/_____/_____
   Monthly basis: ☐9 Months ☐12 Months ☐Other _____
   Percent time of position: _____% ☐Academic ☐Staff Support
10. Is claimant enrolled in the Prudential LTD plan? Yes☐ No☐
    If yes, what was his/her date hired: _____/_____/_____ Policy #_____
11. Have you and the claimant discussed reasonable accommodations which would allow a return to work or would have allowed him/her to continue working? Yes☐ No☐
    Explain:_____
12. If recovered, has claimant returned to work? Yes☐ No☐ When? _____/_____/_____
13. Did this disability occur as a result of claimant's employment? Yes☐ No☐ Disputed☐
    If YES, or under dispute, please provide policy #, name, address, and phone # of Workers' Compensation administrator._____
    _____
14. To the best of your knowledge, is the claimant receiving or entitled to receive benefits from any of these sources?
    Salary Continuance? Yes☐ No☐ Amount $_____ Per_____
    From _____/_____/_____ to _____/_____/_____
    Workers' Comp? Yes☐ No☐ Weekly Benefit $_____ Effective____/____/____
    Employer-Paid Insurance Contract? Yes☐ No☐
    Amount $_____ Per _____ From _____/_____/_____ to _____/_____/_____
    Other? Yes☐ No☐ _____
15. Authorized signature & title of employer representative completing this section:

    _____ _____
    Signature Title

    _____ _____ _____
    Phone Fax Date

Fig. 3



State Universities Retirement System **APPLICATION FOR DISABILITY** **2**
The Prudential Insurance Company of America (if applicable)

EMPLOYER SECTION - PART 2 (Please print in **BLACK INK**)
(Physical/Nonphysical aspects of job - To be completed by employee's Supervisor)

Supervisor's Signature/Title:_____ Date ____/____/____

Employee's Name/Occupation: _____

1. In a typical workday, how many hours does claimant spend in each position, and can he/she alternate positions?

Position	Total no. of hours	May Alternate Positions: At will	15-30 Minutes	Hourly	Never
Sitting	_____	☐	☐	☐	☐
Standing	_____	☐	☐	☐	☐
Walking	_____	☐	☐	☐	☐
Driving	_____	☐	☐	☐	☐

2. Claimant must		Never	Occasionally (¼ -2 ½ hours)	Frequently (2 ½ -5 ½ hours)	Continuously (5 ½ -8 hours)
A. Bend/Stoop		☐	☐	☐	☐
B. Climb		☐	☐	☐	☐
C. Reach above shoulder level		☐	☐	☐	☐
D. Kneel		☐	☐	☐	☐
E. Balance		☐	☐	☐	☐
F. Enter data/keystroke		☐	☐	☐	☐
G. Squat		☐	☐	☐	☐
H. Crawl		☐	☐	☐	☐
I. Crouch		☐	☐	☐	☐
J. Lift	Usual_____lbs.	☐	☐	☐	☐
	Max _____lbs.	☐	☐	☐	☐
K. Carry	Usual_____lbs.	☐	☐	☐	☐
	Max _____lbs.	☐	☐	☐	☐
L. Push/Pull	Usual_____lbs.	☐	☐	☐	☐

3. On the job, claimant uses feet for repetitive movements as in operating foot controls.
Right: ☐Yes ☐No Left: ☐Yes ☐No Both: ☐Yes ☐No

4. On the job, claimant uses hands for repetitive action such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
A. Right	☐	☐	☐
B. Left	☐	☐	☐

5. Does job require:
A. Working at heights? ☐Yes ☐No
B. Exposure to marked changes in temperature & humidity or extremes thereof? ☐Yes ☐No
C. Exposure to dust, fumes, gases, chemicals? ☐Yes ☐No

6. Stress/Nonphysical
Stress level of position is: ☐Low ☐Medium ☐High
☐Occasionally ☐Frequently ☐Continuously

All required information must be included in the Application for Disability Benefits before a disability claim can be finalized. The following section includes directions and examples on how to fill out the Application for Disability and Employer Summary Request Form.

Employers MUST complete the following on the Application for Disability:

Employer Section Part 1. (Fig. 4)

1. Name of University, College, or Agency.

2. Full name of the employee applying for disability.

3. Social Security number of the employee.

4. The last day the employee physically worked.

5. The day the employee became disabled.

6. Last day paid: Last day paid is the date when all sick leave and vacation (if used) has been paid out.

7. The beginning and ending dates for the last pay period for which the employee will receive pay.

8. Check box that applies **(SURS requires that this be answered).**

9. Basic monthly earnings is the rate the employee received on his/her last day worked, and includes the effective date for this rate. Monthly basis is the number of months worked in a year. This includes percent of time and status of employment by checking the box which applies.

10. Check box that applies, and if Yes, explain (Indicate if any part of this is paid for by the employer).

11. Check box that applies, and if Yes, explain (List the accommodations).

12. Check the box that applies and if Yes, include the date they returned to work.

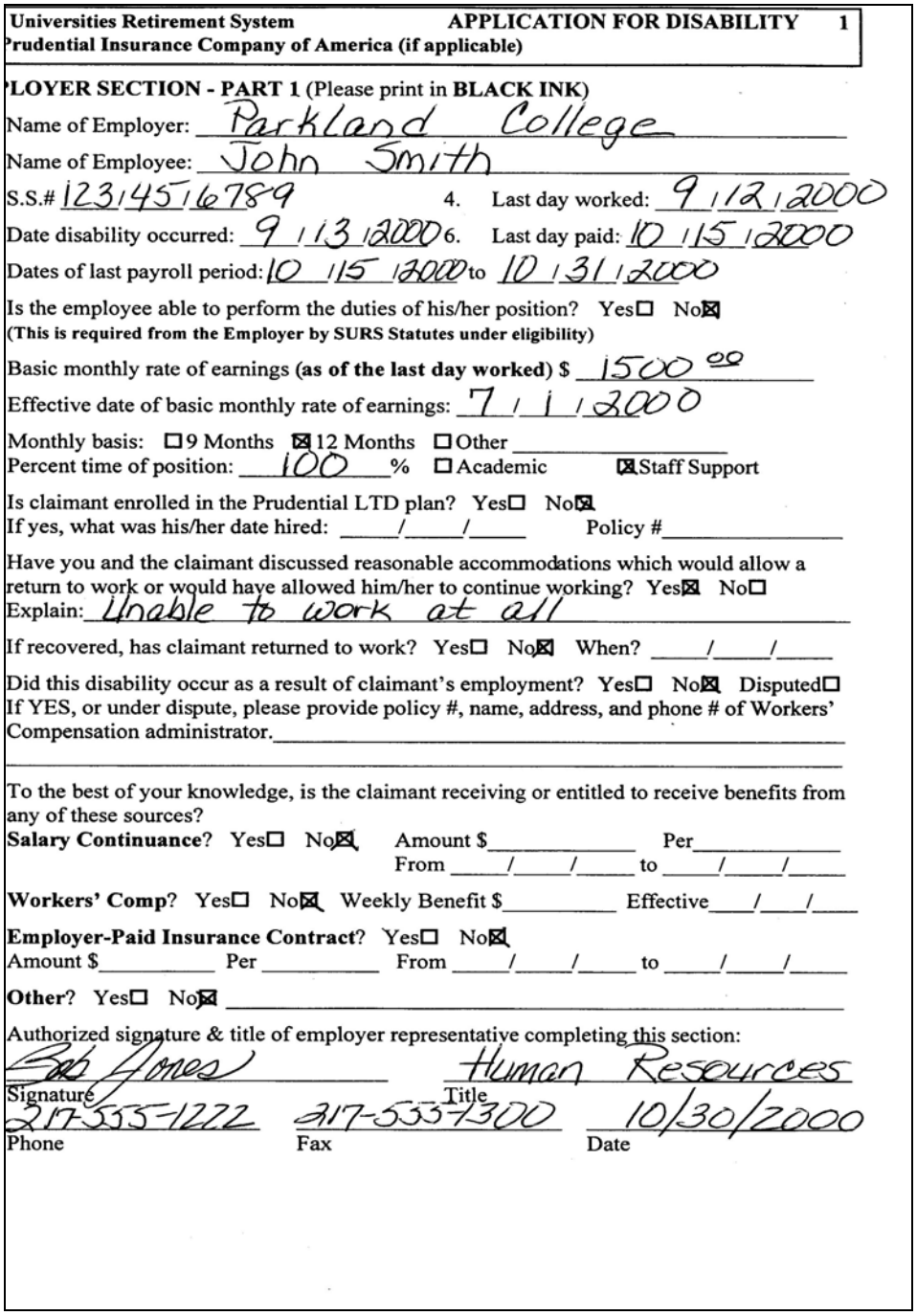
13. Check box that applies and if Yes, or disputed, include information requested.

14. Check the boxes that applies and if Yes, include all the information requested.

15. To be completed in full by the individual responsible for filling out this application.

Employer Section Part 1

Fig. 4



Universities Retirement System **APPLICATION FOR DISABILITY** 1
Prudential Insurance Company of America (if applicable)

PLOYER SECTION - PART 1 (Please print in **BLACK INK**)

Name of Employer: Parkland College

Name of Employee: John Smith

S.S.# 123 45 6789 4. Last day worked: 9 / 12 / 2000

Date disability occurred: 9 / 13 / 2000 6. Last day paid: 10 / 15 / 2000

Dates of last payroll period: 10 / 15 / 2000 to 10 / 31 / 2000

Is the employee able to perform the duties of his/her position? Yes☐ No☒
(This is required from the Employer by SURS Statutes under eligibility)

Basic monthly rate of earnings **(as of the last day worked)** $ 1500 00

Effective date of basic monthly rate of earnings: 7 / 1 / 2000

Monthly basis: ☐9 Months ☒12 Months ☐Other _____
Percent time of position: 100 % ☐Academic ☒Staff Support

Is claimant enrolled in the Prudential LTD plan? Yes☐ No☒
If yes, what was his/her date hired: ____/____/____ Policy #_____

Have you and the claimant discussed reasonable accommodations which would allow a return to work or would have allowed him/her to continue working? Yes☒ No☐
Explain: Unable to work at all

If recovered, has claimant returned to work? Yes☐ No☒ When? ____/____/____

Did this disability occur as a result of claimant's employment? Yes☐ No☒ Disputed☐
If YES, or under dispute, please provide policy #, name, address, and phone # of Workers' Compensation administrator._____

To the best of your knowledge, is the claimant receiving or entitled to receive benefits from any of these sources?
Salary Continuance? Yes☐ No☒ Amount $_____ Per_____
From ____/____/____ to ____/____/____

Workers' Comp? Yes☐ No☒ Weekly Benefit $_____ Effective____/____/____

Employer-Paid Insurance Contract? Yes☐ No☒
Amount $_____ Per _____ From ____/____/____ to ____/____/____

Other? Yes☐ No☒ _____

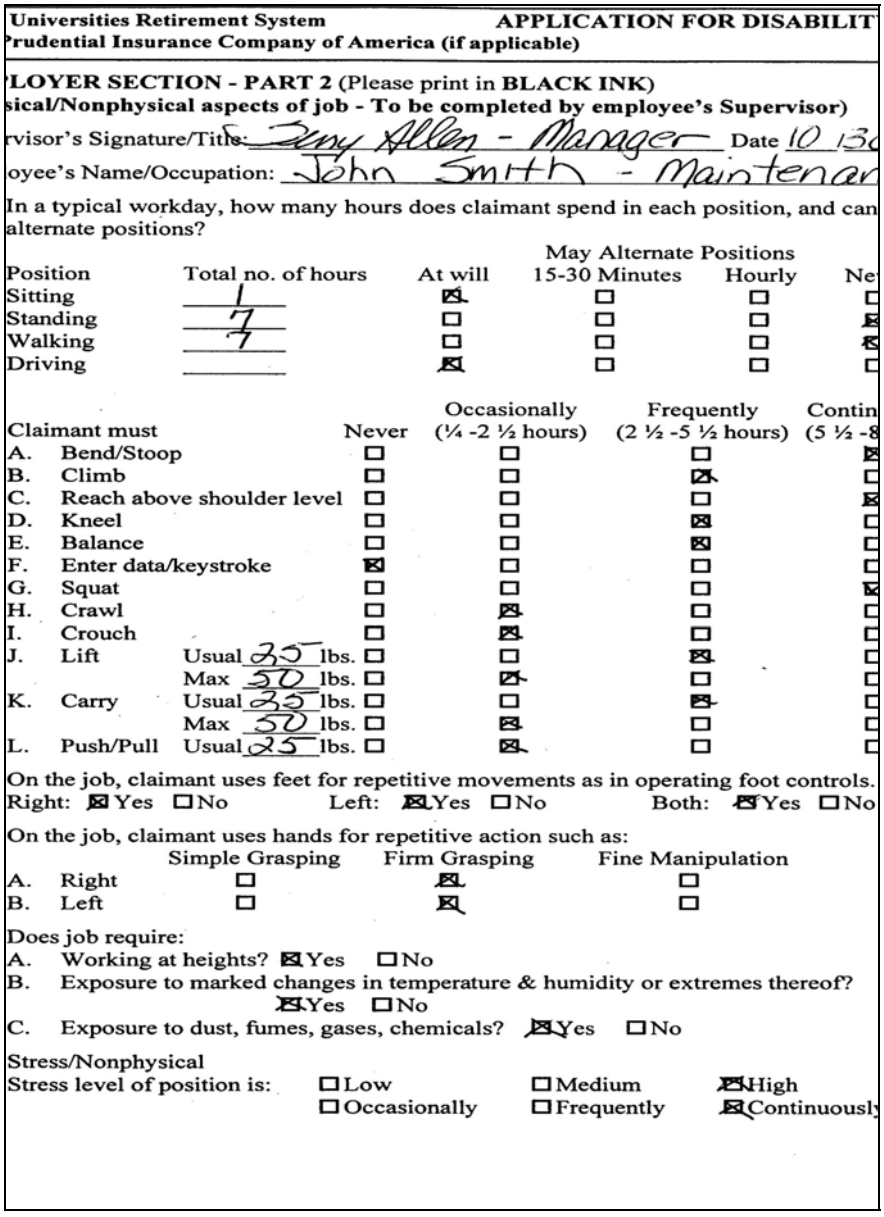
Authorized signature & title of employer representative completing this section:
Bob Jones Human Resources
Signature Title
217-555-1222 217-555-1300 10/30/2000
Phone Fax Date

Employers MUST also complete the following:

Employer Section Part 2 (Fig. 5)

This section must be filled out and signed by the claimant's supervisor.
1 through 8: Complete these sections based on the employee's job description.

Fig. 5



Universities Retirement System **APPLICATION FOR DISABILIT**
Prudential Insurance Company of America (if applicable)

LOYER SECTION - PART 2 (Please print in **BLACK INK**)
sical/Nonphysical aspects of job - To be completed by employee's Supervisor)

rvisor's Signature/Title: Jerry Allen - Manager Date 10 13

oyee's Name/Occupation: John Smith - Maintenan

In a typical workday, how many hours does claimant spend in each position, and can alternate positions?

Position	Total no. of hours	May Alternate Positions: At will	15-30 Minutes	Hourly	Ne
Sitting	1	☒	☐	☐	☐
Standing	7	☐	☐	☐	☒
Walking	7	☐	☐	☐	☒
Driving		☒	☐	☐	☐

Claimant must		Never	Occasionally (¼ -2 ½ hours)	Frequently (2 ½ -5 ½ hours)	Contin (5 ½ -8
A. Bend/Stoop		☐	☐	☐	☒
B. Climb		☐	☐	☒	☐
C. Reach above shoulder level		☐	☐	☐	☒
D. Kneel		☐	☐	☒	☐
E. Balance		☐	☐	☒	☐
F. Enter data/keystroke		☒	☐	☐	☐
G. Squat		☐	☐	☐	☒
H. Crawl		☐	☒	☐	☐
I. Crouch		☐	☒	☐	☐
J. Lift	Usual 25 lbs.	☐	☐	☒	☐
	Max 50 lbs.	☐	☒	☐	☐
K. Carry	Usual 25 lbs.	☐	☐	☒	☐
	Max 50 lbs.	☐	☒	☐	☐
L. Push/Pull	Usual 25 lbs.	☐	☒	☐	☐

On the job, claimant uses feet for repetitive movements as in operating foot controls.
Right: ☒ Yes ☐ No Left: ☒ Yes ☐ No Both: ☒ Yes ☐ No

On the job, claimant uses hands for repetitive action such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
A. Right	☐	☒	☐
B. Left	☐	☒	☐

Does job require:
A. Working at heights? ☒ Yes ☐ No
B. Exposure to marked changes in temperature & humidity or extremes thereof?
☒ Yes ☐ No
C. Exposure to dust, fumes, gases, chemicals? ☒ Yes ☐ No

Stress/Nonphysical
Stress level of position is: ☐ Low ☐ Medium ☒ High
☐ Occasionally ☐ Frequently ☒ Continuously

Remember:

Read all directions carefully. **Do not separate any pages.** The application includes three sections: Employer, Claimant, and Physician.

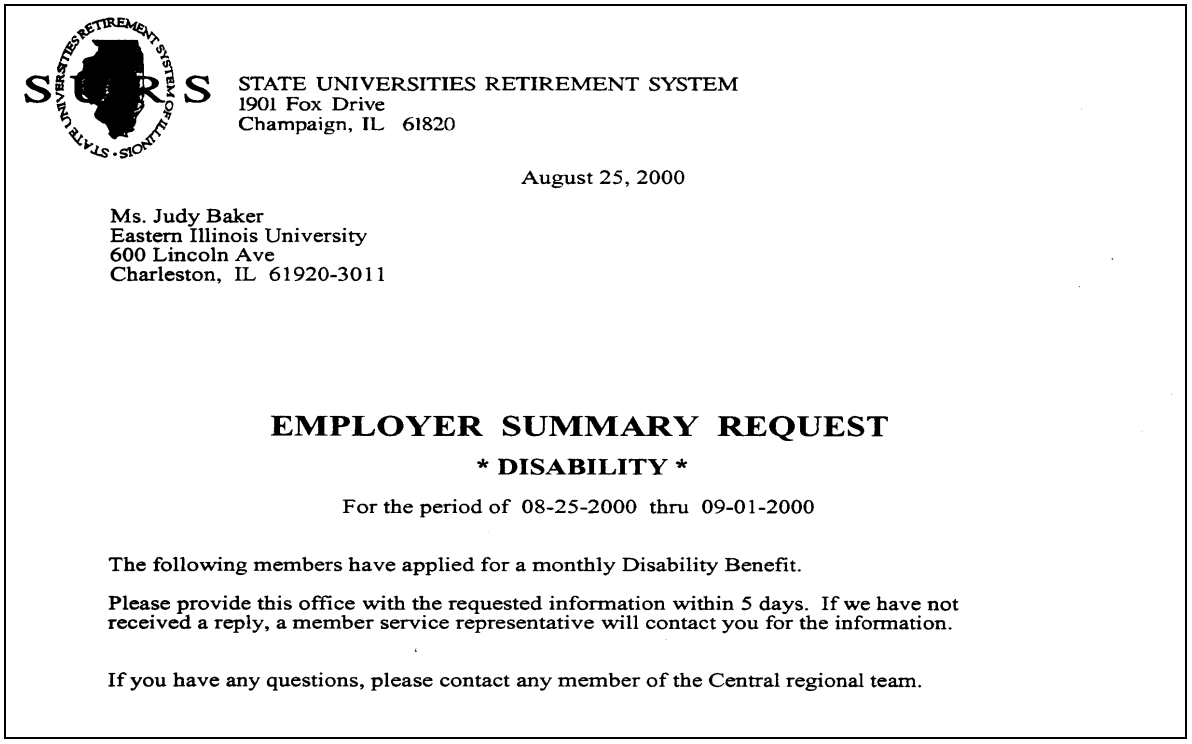
When the Employer Section is complete, return the application to the employee. The remaining portion of the application will be the employee's responsibility to complete.

Once the application is completed in full, the employee **must** mail this application to SURS, intact. If the application is incomplete, SURS will return it to the employee.

Employer's Summary Request for Disability: (Fig. 6)

The Employer Summary Request Report is a computer-generated form that SURS will send only if more information is needed because it was missing or not completely known when the Application for Disability was filled out. An example would be when the employer can only estimate the last date paid on the application.

Fig. 6



STATE UNIVERSITIES RETIREMENT SYSTEM
1901 Fox Drive
Champaign, IL 61820

August 25, 2000

Ms. Judy Baker
Eastern Illinois University
600 Lincoln Ave
Charleston, IL 61920-3011

EMPLOYER SUMMARY REQUEST

*** DISABILITY ***

For the period of 08-25-2000 thru 09-01-2000

The following members have applied for a monthly Disability Benefit.

Please provide this office with the requested information within 5 days. If we have not received a reply, a member service representative will contact you for the information.

If you have any questions, please contact any member of the Central regional team.

Fig7.

Employer Summary Report
* Disability *

Part A. - Member Information

Name Mike Brewer SS# 123-45-6789
Expected last day worked. 03-10-2001
Expected last day paid. 03-10-2001
Expected disability leave begin date. 03-10-2001

Part B. - Employer Information

01. Employment Status: ☐ Academic ☐ Staff ☐ Police/Firefighter

02. Actual last day worked. ____/____/____ 03. Percent status on last day worked. ____%

04. Actual last day paid. ____/____/____ 05. Actual disability leave begin date. ____/____/____

06. Ending date of last payroll period. ____/____/____

07. Monthly rate of pay on last day worked. $ ____ 08. Effective date of the rate. ____/____/____

09. Number of months normally worked in a year: ☐ 12 ☐ 9 ☐ Other (____)

10. Did employee become disabled while on leave or vacation ? ☐ Yes ☐ No
If yes, indicate the date he/she became disabled. ____/____/____

11. Is this claimant able to perform the duties of his/her position ? ☐ Yes ☐ No

Part C - Other Benefits

Is claimant receiving, or entitled to receive, benefits from any of these sources:

12. Worker's Comp. Disputed. ☐ Yes ☐ No
Amount $____ Per ____ From ____/____/____ To ____/____/____

13. Employer-paid insurance contract.
Amount $____ Per ____ From ____/____/____ To ____/____/____

14. Salary continuance.
Amount $____ Per ____ From ____/____/____ To ____/____/____

15. Other Explain: ____
Amount $____ Per ____ From ____/____/____ To ____/____/____

Part D - Return to Duty

Has claimant returned to duty ?

16. Return date: ____/____/____ 17. Percent returned to duty. ____%

EMPLOYER: ____ SIGNATURE ____
Certifying and Official Signature

PHONE# ( ) DATE / /

If you receive this form, make sure all the following information is filled out completely and accurately before returning it to SURS (Fig. 8).

Part B Employer Information

1) Employment Status: Indicate academic, staff, or police/firefighter.
2) Actual Last Day Worked: The last day the employee physically worked.
3) Percent of Status on Last Day Worked: Percent of time employee worked prior to disability. This is the percent of time the employee worked in relation to the full time standard.

   Example: Normally, a Building Services worker position works 40 hours per week. A Building Services worker working 28 hours per week would be 70%.
4) Actual Last Pay Date: Last day includes all sick leave and vacation paid, if used.
5) Actual Disability Leave Begin Date: The day following the last day paid.
6) Ending Date of the Last Payroll Period: The final payroll reported to SURS. The last date of the pay period for which the employee will receive pay.
7) Monthly Rate of Pay on Last Day Worked: The amount earned each month as of the last day worked.
8) Effective Date of the Monthly Rate of Pay: The date the monthly rate went into effect.
9) Number of Months Normally Worked in a Year: Indicate 12, 9, or other. (If "other", please explain.) SURS disability benefits will be paid over the same amount of months.
10) Indicate if employee became disabled while on leave or on vacation.
11) Is claimant able to perform the duties of his/her position? Indicate yes or no. By Illinois Statute, SURS is required to obtain the answer.

Part C Other Benefits

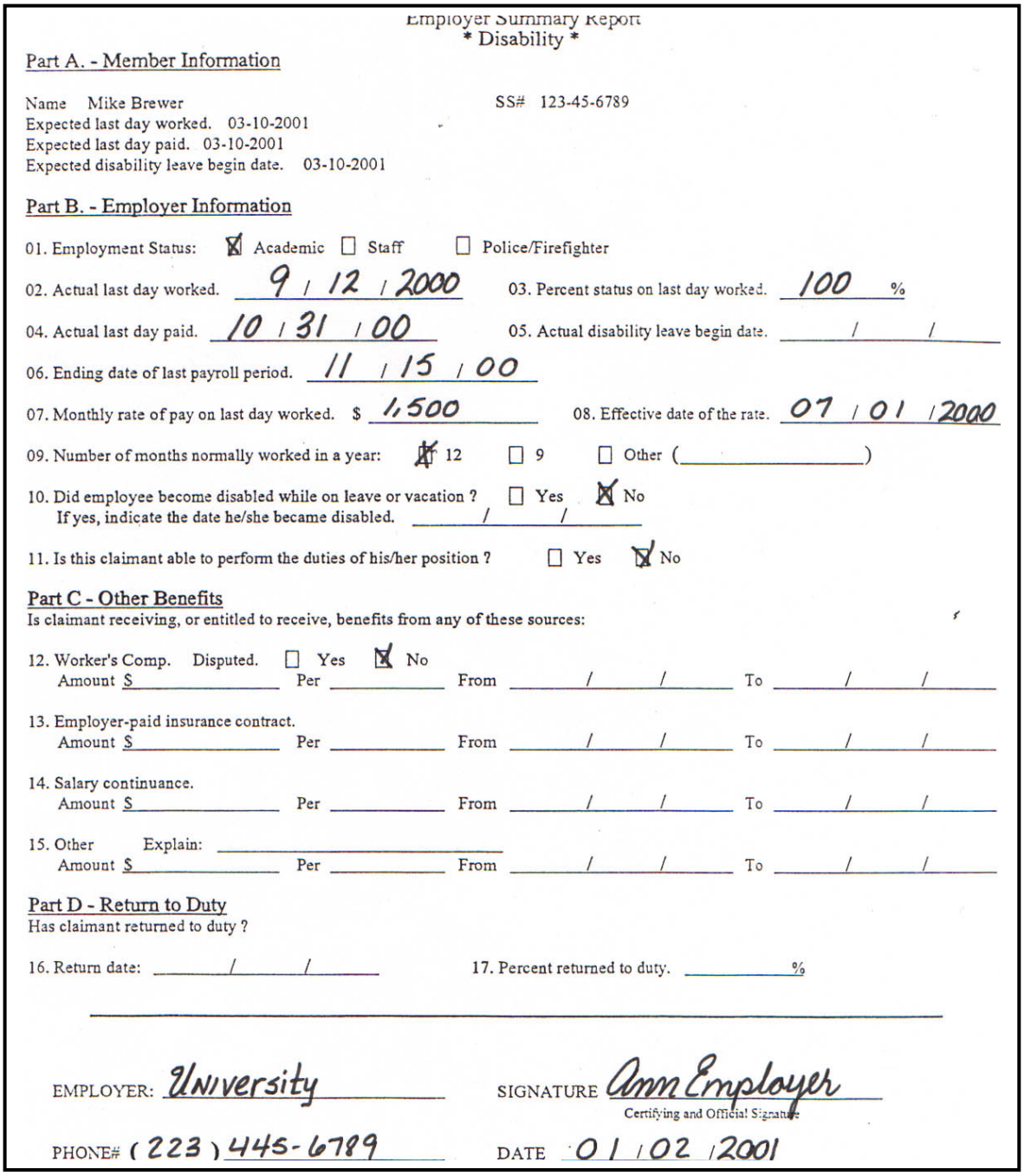
If any "other" benefit is relevant, enter the amount of the benefit, mode of payment of the benefit, (monthly, annually, etc.) and the beginning and ending dates of the policy period.

12) Workers Compensation: Document all information regarding a Worker's Compensation claim, including if it is being disputed.
13) Employer Paid Insurance Contract: Any disability insurance that is paid all or in part by the employer.
14) Salary Continuance: Seldom applicable. Identifies monies payable to an employee other than earnings, sick leave, or vacation payments.
15) Other: Any benefits that do not fall into any of the categories previously listed.

Part D Return to Duty

16) Return Date: First day employee returns to duty.
17) Percent of Return to Duty: The percent of time the employee is returning to work in relation to the full-time standard (See example in Part B, number 3).

Fig. 8



Employer Summary Report
* Disability *

Part A. - Member Information

Name Mike Brewer SS# 123-45-6789
Expected last day worked. 03-10-2001
Expected last day paid. 03-10-2001
Expected disability leave begin date. 03-10-2001

Part B. - Employer Information

01. Employment Status: ☒ Academic ☐ Staff ☐ Police/Firefighter
02. Actual last day worked. 9 / 12 / 2000 03. Percent status on last day worked. 100 %
04. Actual last day paid. 10 / 31 / 00 05. Actual disability leave begin date. / /
06. Ending date of last payroll period. 11 / 15 / 00
07. Monthly rate of pay on last day worked. $ 1,500 08. Effective date of the rate. 07 / 01 / 2000
09. Number of months normally worked in a year: ☒ 12 ☐ 9 ☐ Other (_____)
10. Did employee become disabled while on leave or vacation ? ☐ Yes ☒ No
If yes, indicate the date he/she became disabled. / /
11. Is this claimant able to perform the duties of his/her position ? ☐ Yes ☒ No

Part C - Other Benefits
Is claimant receiving, or entitled to receive, benefits from any of these sources:

12. Worker's Comp. Disputed. ☐ Yes ☒ No
Amount $ Per From / / To / /
13. Employer-paid insurance contract.
Amount $ Per From / / To / /
14. Salary continuance.
Amount $ Per From / / To / /
15. Other Explain:
Amount $ Per From / / To / /

Part D - Return to Duty
Has claimant returned to duty ?

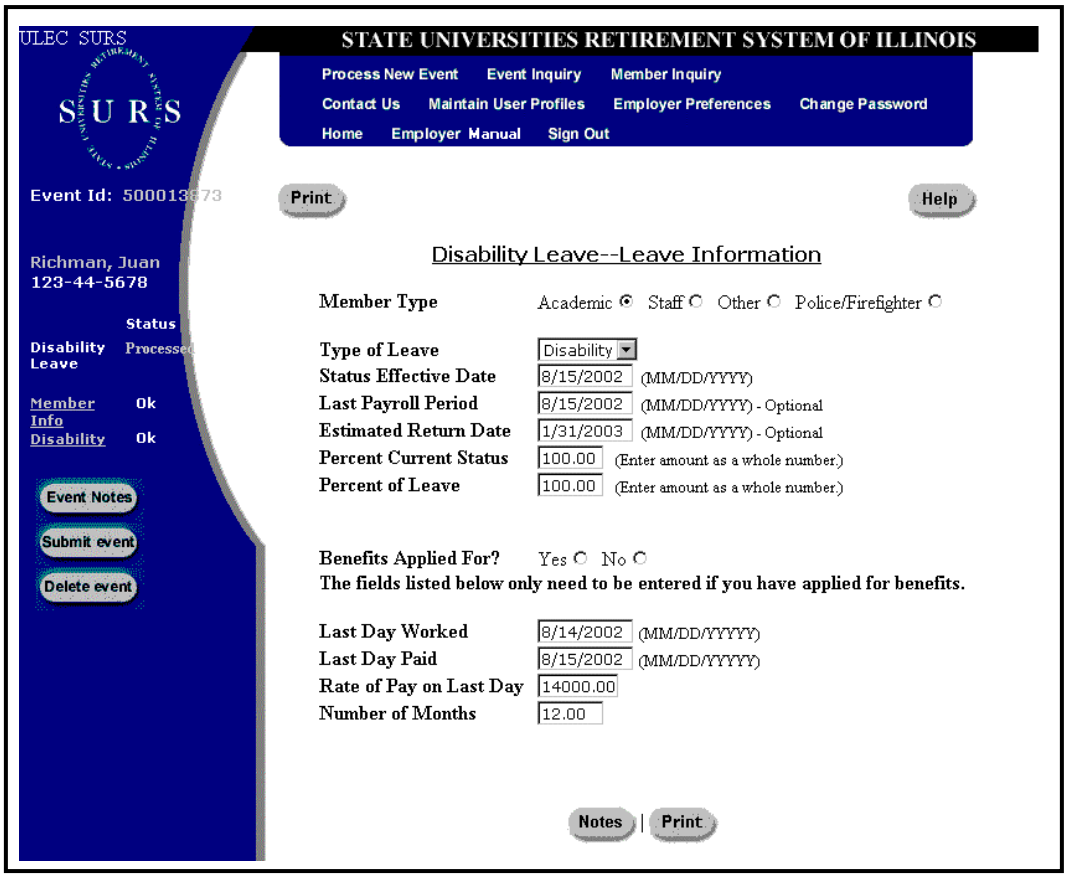
16. Return date: / / 17. Percent returned to duty. %

EMPLOYER: University SIGNATURE Ann Employer
Certifying and Official Signature
PHONE# (223) 445-6789 DATE 01 / 02 / 2001

Disability Leave Event: (Fig.9)

Since a disability would represent a change in the employee's work status, the employer would create and submit a Disability Leave event on the SURS Employer Website (Fig. 9). This information will still need to be entered on the Disability Application.

Fig. 9



1. Verify and update the Member Information screen (Membership, page 6, figure 1).
2. Select the Type of Leave from the drop down menu.
3. Status Effective Date is the date that the employee's disability began.
4. Last Payroll Period is the last date of the last payroll period in which the employee worked.
5. Estimated Return Date is the date that it is anticipated the employee will return from leave.
6. Percent of Current Status is the employee's status on the date the leave began.
7. Percent of Leave is the percent of time the employee will be on leave.
8. Benefits Applied for should indicate if the employee has or has not applied for disability benefits with SURS.

If benefits are being applied for, include:

9. Last Day Worked is the date the employee last worked.
10. Last Day Paid includes all sick leave and vacation (if used) paid.
11. Rate Of Pay On Last Day is the monthly rate of pay earned each month as of the last day worked.
12. Number of months is the number of months the employee is paid over.

Return From Disability Leave:

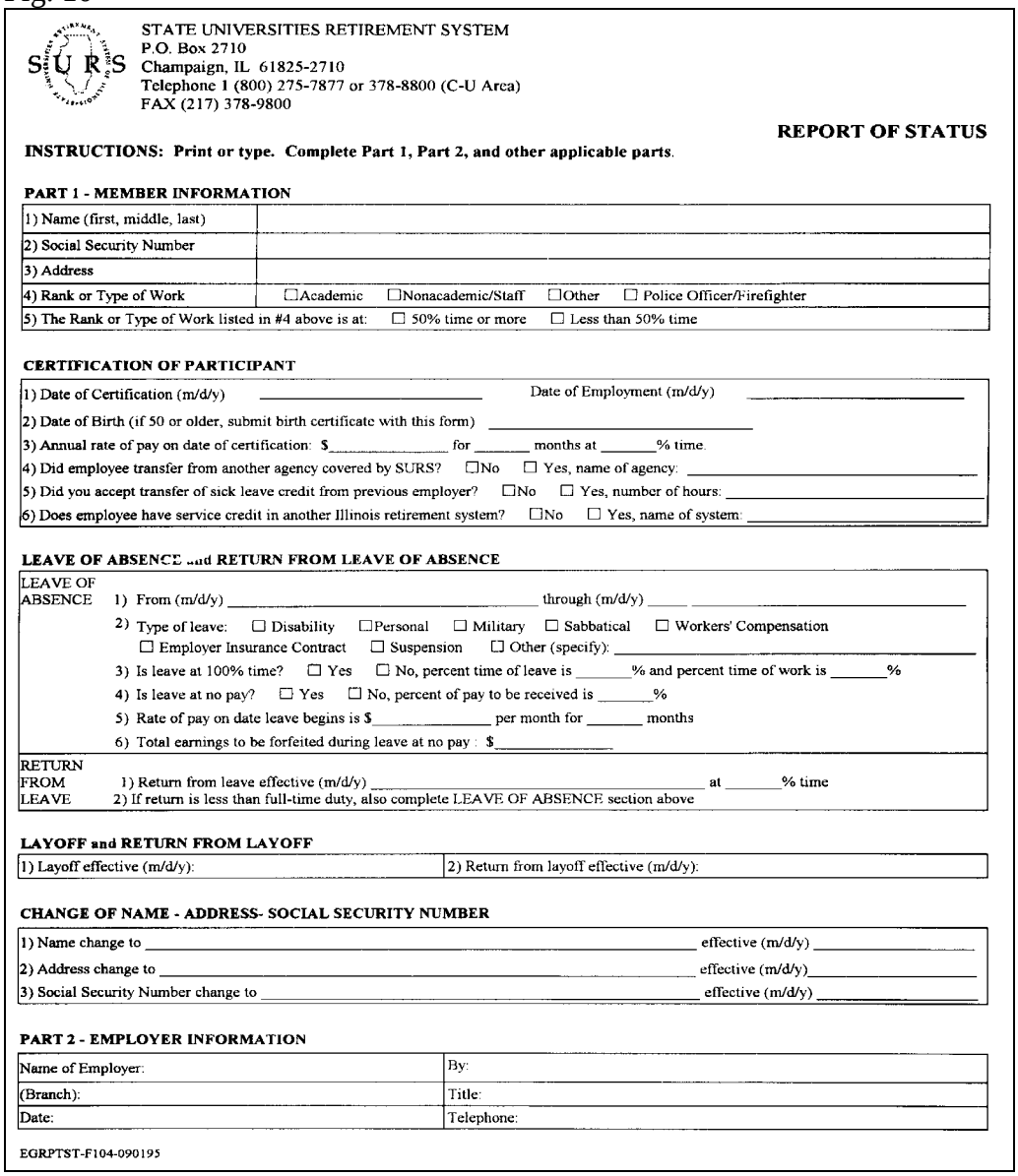
Return From Leave At Part Time

Employees allowed to return to work part-time will have their disability payment reduced by the amount of their earnings in excess of the actual disability benefit they are receiving every month from SURS. (Fig. 10 and 11) The employer must send a Report of Status or Return From Leave Web event to SURS indicating the day the employee has returned to work, and at what percent of time.

Return From Leave At Less Than 100%

If an employee is returning from leave at less than 100% time a Report of Status form (Fig. 10) must be completed and submitted to SURS (Note: Reporting an employee returning from leave at less than 100% cannot be reported on the SURS Employer Website).

Fig. 10



STATE UNIVERSITIES RETIREMENT SYSTEM
P.O. Box 2710
Champaign, IL 61825-2710
Telephone 1 (800) 275-7877 or 378-8800 (C-U Area)
FAX (217) 378-9800

REPORT OF STATUS

INSTRUCTIONS: Print or type. Complete Part 1, Part 2, and other applicable parts.

PART 1 - MEMBER INFORMATION

1) Name (first, middle, last)	
2) Social Security Number	
3) Address	
4) Rank or Type of Work	☐Academic ☐Nonacademic/Staff ☐Other ☐ Police Officer/Firefighter
5) The Rank or Type of Work listed in #4 above is at:	☐ 50% time or more ☐ Less than 50% time

CERTIFICATION OF PARTICIPANT

1) Date of Certification (m/d/y) _____ Date of Employment (m/d/y) _____
2) Date of Birth (if 50 or older, submit birth certificate with this form) _____
3) Annual rate of pay on date of certification: $_____ for _____ months at _____% time.
4) Did employee transfer from another agency covered by SURS? ☐No ☐ Yes, name of agency: _____
5) Did you accept transfer of sick leave credit from previous employer? ☐No ☐ Yes, number of hours: _____
6) Does employee have service credit in another Illinois retirement system? ☐No ☐ Yes, name of system: _____

LEAVE OF ABSENCE and RETURN FROM LEAVE OF ABSENCE

LEAVE OF ABSENCE
1) From (m/d/y) _____ through (m/d/y) _____
2) Type of leave: ☐ Disability ☐Personal ☐ Military ☐ Sabbatical ☐ Workers' Compensation ☐ Employer Insurance Contract ☐ Suspension ☐ Other (specify): _____
3) Is leave at 100% time? ☐ Yes ☐ No, percent time of leave is _____% and percent time of work is _____%
4) Is leave at no pay? ☐ Yes ☐ No, percent of pay to be received is _____%
5) Rate of pay on date leave begins is $_____ per month for _____ months
6) Total earnings to be forfeited during leave at no pay : $_____

RETURN FROM LEAVE
1) Return from leave effective (m/d/y) _____ at _____% time
2) If return is less than full-time duty, also complete LEAVE OF ABSENCE section above

LAYOFF and RETURN FROM LAYOFF

1) Layoff effective (m/d/y):	2) Return from layoff effective (m/d/y):

CHANGE OF NAME - ADDRESS- SOCIAL SECURITY NUMBER

1) Name change to _____ effective (m/d/y) _____
2) Address change to _____ effective (m/d/y) _____
3) Social Security Number change to _____ effective (m/d/y) _____

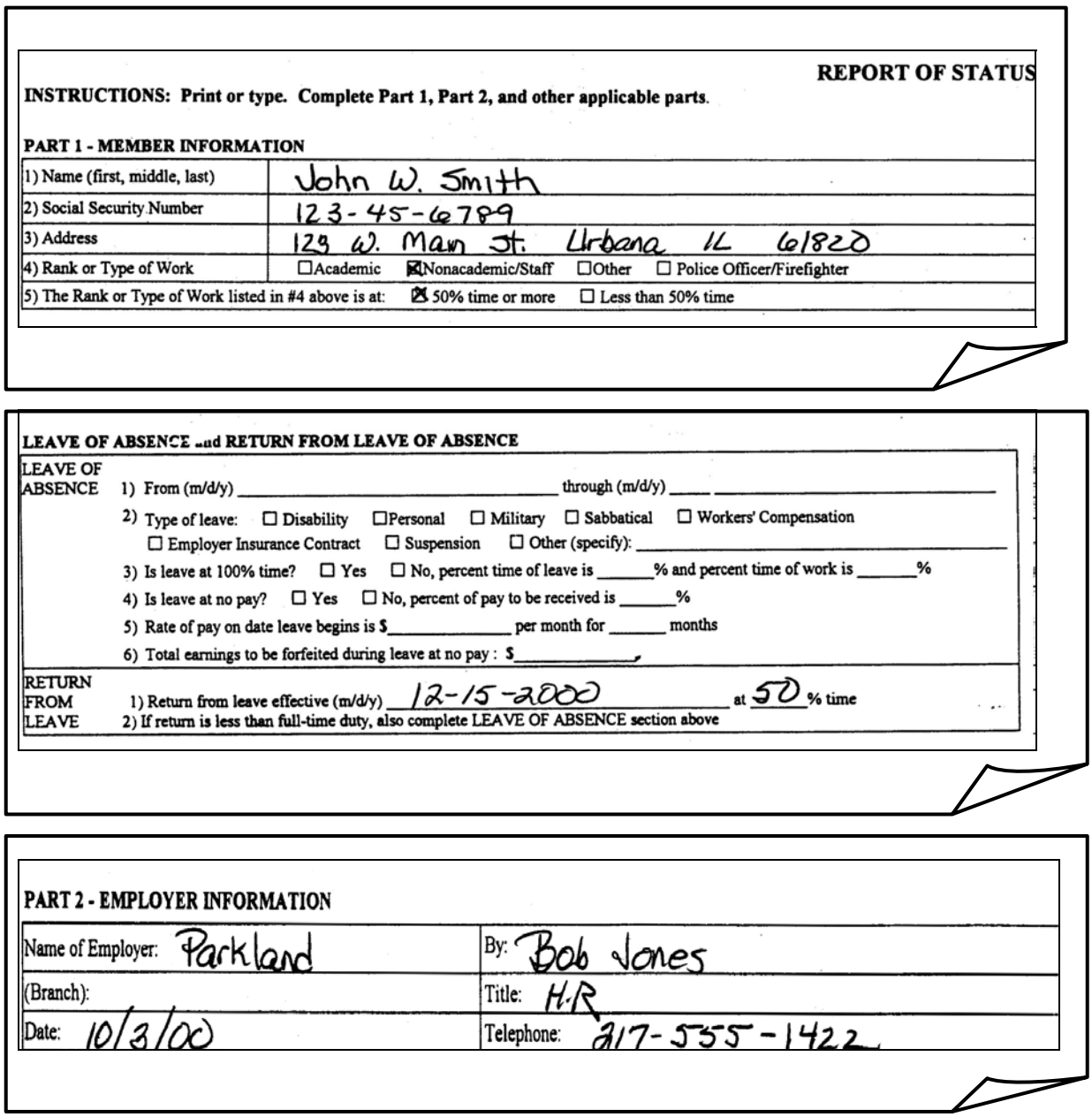
PART 2 - EMPLOYER INFORMATION

Name of Employer:	By:
(Branch):	Title:
Date:	Telephone:

EGRPTST-F104-090195

The three sections indicated below are the only sections necessary to complete on the Report of Status. Fill in all necessary sections, and mail the report back to SURS.

Fig. 11



REPORT OF STATUS

INSTRUCTIONS: Print or type. Complete Part 1, Part 2, and other applicable parts.

PART 1 - MEMBER INFORMATION

1) Name (first, middle, last)	John W. Smith
2) Social Security Number	123-45-6789
3) Address	129 W. Main St. Urbana IL 61820
4) Rank or Type of Work	☐Academic ☒Nonacademic/Staff ☐Other ☐ Police Officer/Firefighter
5) The Rank or Type of Work listed in #4 above is at:	☒ 50% time or more ☐ Less than 50% time

LEAVE OF ABSENCE and RETURN FROM LEAVE OF ABSENCE

LEAVE OF ABSENCE

1) From (m/d/y) _____ through (m/d/y) _____

2) Type of leave: ☐ Disability ☐Personal ☐ Military ☐ Sabbatical ☐ Workers' Compensation ☐ Employer Insurance Contract ☐ Suspension ☐ Other (specify): _____

3) Is leave at 100% time? ☐ Yes ☐ No, percent time of leave is _____% and percent time of work is _____%

4) Is leave at no pay? ☐ Yes ☐ No, percent of pay to be received is _____%

5) Rate of pay on date leave begins is $_____ per month for _____ months

6) Total earnings to be forfeited during leave at no pay : $_____

RETURN FROM LEAVE

1) Return from leave effective (m/d/y) 12-15-2000 at 50 % time

2) If return is less than full-time duty, also complete LEAVE OF ABSENCE section above

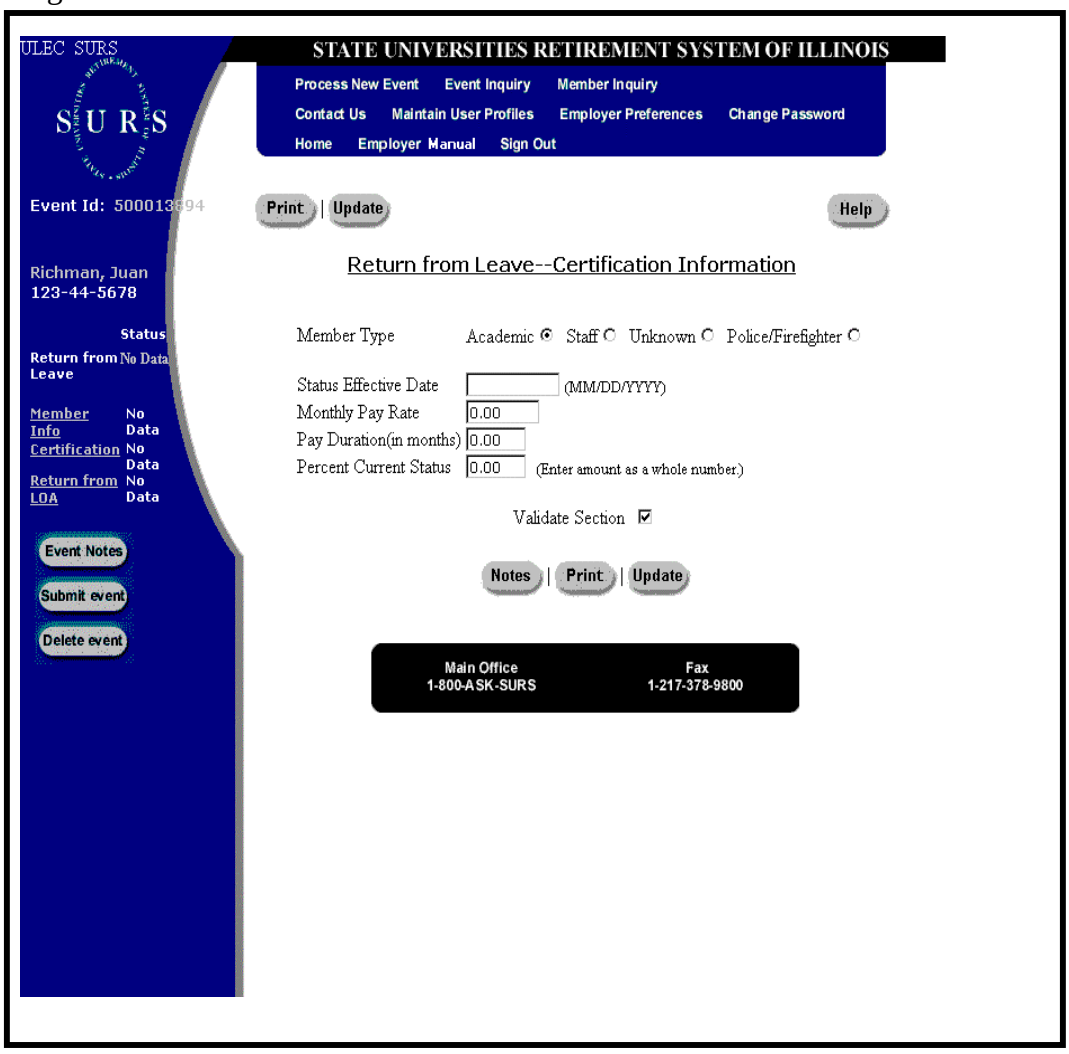
PART 2 - EMPLOYER INFORMATION

Name of Employer: Parkland	By: Bob Jones
(Branch):	Title: H.R.
Date: 10/3/00	Telephone: 217-555-1422

Return From Leave At 100%

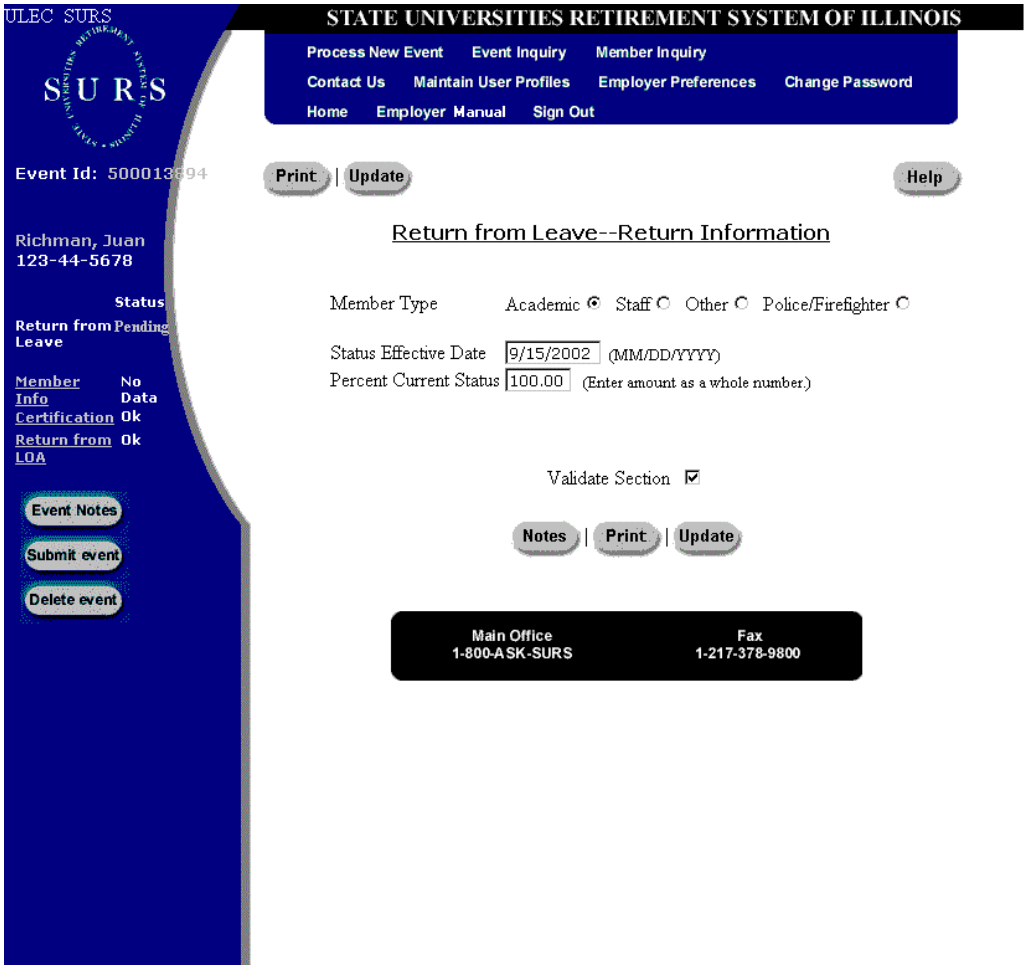
A Return From Leave event should be created on the SURS Employer Website when returning an employee from a Disability Leave at 100%. (Fig. 12 and 13)

Fig. 12



1) Verify and update the Member Information Screen (Membership, Page 6, Fig. 1).
2) Status Effective Date is the date that the employee returned from leave.
3) Monthly Pay Rate is the monthly amount received by the employee upon return from leave.
4) Pay Duration is the number of months over which the employee is paid.
5) Percent of Current Status should reflect the actual percent of time worked upon returning from leave.

Fig. 13



On the Return Information screen, enter the Percent Current Status as the same percentage as in step 5 on the previous page. *This identical information is entered on two separate screens because it is a two step process to change the member's status to active and to return the member from leave.*

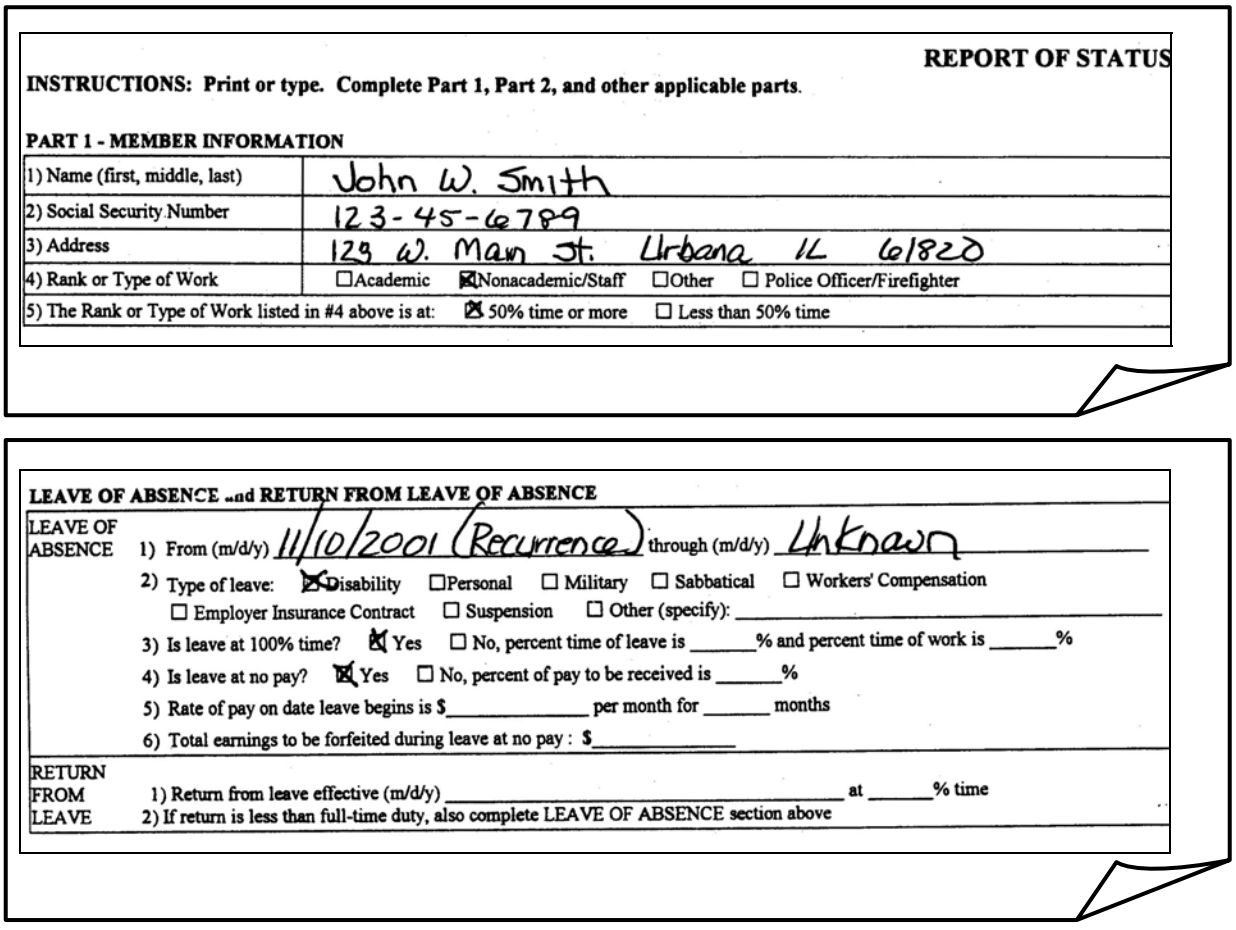
An Employee Has Recurrance

If an employee returns to work for less than 30 calendar days and becomes disabled due to the same cause, it will be considered a recurrence of the previous disability. In this case, the employee will not be required to meet another 60-day waiting period.

If the recurrence is **less than 5 days**, a new Application for Disability will not be necessary. SURS will require a Summary Report or an Employer's Report of Disability (Fig. 14**)**

If an employee is able to work **five or more days, but less than 30**, SURS will require the completion of a new Application for Disability.

Fig. 14



REPORT OF STATUS

INSTRUCTIONS: Print or type. Complete Part 1, Part 2, and other applicable parts.

PART 1 - MEMBER INFORMATION

1) Name (first, middle, last)	John W. Smith
2) Social Security Number	123-45-6789
3) Address	129 W. Main St. Urbana IL 61820
4) Rank or Type of Work	☐Academic ☒Nonacademic/Staff ☐Other ☐ Police Officer/Firefighter
5) The Rank or Type of Work listed in #4 above is at:	☒ 50% time or more ☐ Less than 50% time

LEAVE OF ABSENCE and RETURN FROM LEAVE OF ABSENCE

LEAVE OF ABSENCE

1) From (m/d/y) 11/10/2001 (Recurrence) through (m/d/y) Unknown

2) Type of leave: ☒Disability ☐Personal ☐ Military ☐ Sabbatical ☐ Workers' Compensation
☐ Employer Insurance Contract ☐ Suspension ☐ Other (specify): _____

3) Is leave at 100% time? ☒ Yes ☐ No, percent time of leave is _____% and percent time of work is _____%

4) Is leave at no pay? ☒ Yes ☐ No, percent of pay to be received is _____%

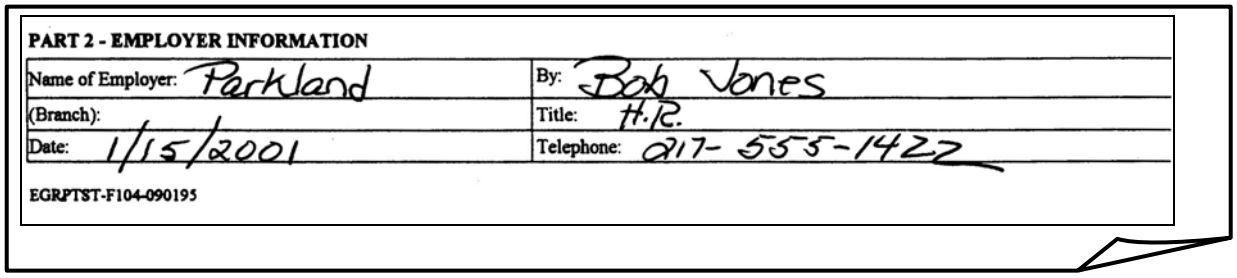
5) Rate of pay on date leave begins is $_____ per month for _____ months

6) Total earnings to be forfeited during leave at no pay : $_____

RETURN FROM LEAVE

1) Return from leave effective (m/d/y) _____ at _____% time

2) If return is less than full-time duty, also complete LEAVE OF ABSENCE section above



PART 2 - EMPLOYER INFORMATION

Name of Employer: Parkland	By: Bob Jones
(Branch):	Title: H.R.
Date: 1/15/2001	Telephone: 217-555-1422

EGRPTST-F104-090195

Employee Responsibilities

Forms Required:

1. Application for Disability (Claimant and Physician Sections; 5 pages)
2. Report of Earnings
3. Recheck Reports

1. Application for Disability:

To initiate the disability process, the employee must contact the employer. The process **does not** start at SURS. SURS will not mail the applications to the disabled employee.

When the Employer section is complete, the employee must complete the Claimant Section of the application (Fig. 14).

When the Claimant Section (Fig.15a-b) is complete, the Physician Section (Fig 15c-e) must be filled out. It is the employee's responsibility to bring this section to the physician.

If the Physician Section does not include copies of medical reports and documentation to substantiate what was reported on the application, a letter is sent requesting the information.

Once all three sections of the application are completed, the employee must mail the booklet to SURS. SURS will then notify the employee if anything else is needed.

Fig. 15a

Claimant Section - Part 1

State Universities Retirement System **APPLICATION FOR DISABILITY 3**

CLAIMANT SECTION - PART 1 (Please print in **BLACK INK**)

1. Full Name:_____ **2.** Social Security #_____-_____-_____

3. Address:_____ **4.** Birth Date____/____/____

_____ **5.** Home Phone (____)_____-_____

_____ **6.** WorkPhone (____)_____-_____

6. Sex: ☐Male ☐ Female **7.** Martial Status: ☐ Single ☐Married ☐Separated ☐ Widowed ☐Divorced

8. Occupation:_____ **9.** ☐Academic ☐Support Staff

Section II

1. Nature of illness and when symptoms first appeared, or describe how and where accident occurred:_____

2. Date first unable to work because of disability:_____/_____/_____

3. Which of your job duties are you unable to perform?_____

4. What accommodations do you feel could be made by your employer to allow you to return to work?_____

5. Have you returned to work? ☐**Yes** ☐**No** Part-time___/___/___ Full-time___/___/___
Were you disabled during vacation, leave, layoff? ☐**Yes** ☐**No** Date:____/____/____

6. Names and addresses of all physicians who have been consulted for this condition. Include dates of consultation.

Name of Physician	**Address**	**First visit**	**Last Visit**
_____	_____ _____ _____ Phone #_____	___/___/___	___/___/___
_____	_____ _____ _____ Phone #_____	___/___/___	___/___/___

Section III - Authorization To Release Information

I authorize any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institute, law enforcement agency, or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information of me to give to SURS and Fortis Benefits, if applicable, or its representative, any and all such information. I UNDERSTAND the information obtained by use of this authorization will be used to determine the eligibility for benefits. I understand that I can revoke this consent at any time as it relates to mental health or developmental disabilities services. I know that a photographic copy of this authorization shall be as valid as the original. I know that I have the right to inspect and copy the information to be disclosed. I understand that a refusal to, or revocation of, consent to the release of this information may result in my claim being denied. I agree this authorization shall be valid for the duration of the claim. If I receive a disability benefit greater than that which I should have been paid, I understand SURS has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

_____ _____

Signature of Claimant **Date**

Fig. 15b

Claimant Section - Part 2

State Universities Retirement System **APPLICATION FOR DISABILITY 4**

CLAIMANT SECTION PART 2 (Please print in **BLACK INK)**

Section I

I have been a member of : ☐ State Employees' Retirement System of Illinois
☐ State Teachers' Retirement System of Illinois
☐ All of my credits have been under the State Universities Retirement System

Section II

Check if you are receiving or entitled to receive benefits from any of the following sources:
☐ Salary, Wages or Commissions ☐ Social Security Disability ☐ Workers' Compensation
☐ Employer Paid Insurance Contract ☐ Other Sources

For each source marked, please provide the following information:

Source_____ Amount Per Month $_____ Effective Date_____
Source_____ Amount Per Month $_____ Effective Date_____
Provide documentation of any source indicated above; for example, award notices, denial notices or applications.

Section III - Bank Authorization

I Hereby request that SURS send my monthly disability benefit payments to (check **one** box only):

☐ My Federally Insured Financial Institution ☐ My Home
Name of Financial Institution:_____
Mailing Address:_____
_____
_____
Phone # of Financial Institution: (_____)_____-_____
Account # _____ ☐ Checking (attach voided check or deposit ticket)
☐ Savings

Section IV - Election for Federal Income Tax Withholding

I understand that if I fail to make one of the elections provided in this section (Section IV), Federal income tax will automatically be withheld by SURS from my disability benefit, based on the IRS tables for a married person with 3 withholding allowances.

INSTRUCTIONS: Check one option only and enter number of withholding allowances.

☐ **OPTION 1** - DO NOT withhold Federal income tax from my benefit payments.
☐ **OPTION 2** - Withhold Federal income tax. Calculate using ____withholding allowances with SINGLE marital status.
☐ **OPTION 3** - Withhold Federal income tax. Calculate using ____withholding allowances with MARRIED marital status.
☐ **OPTION 4** - Withhold Federal income tax. Calculate using ____withholding allowances with ___ SINGLE OR ___ MARRIED marital status. Also withhold an additional $_____ from EACH payment.
☐ **OPTION 5** - Withhold a specific amount from each payment. Withhold $_____ from EACH payment.

Fig. 15c

Physician Section

State Universities Retirement System **APPLICATION FOR DISABILITY 5**

ATTENDING PHYSICIAN'S INITIAL STATEMENT OF DISABILITY
The claimant must pay any costs for the completion of this form and copy of records.

To the Attending Physician
1. Please read the following instructions before completing this form.
2. Do not separate the pages of this claim statement. An authorization to release information can be found in Part 1 of the Claimant's Statement on Page 3.
3. Clearly print this form with black ink. Fully complete each applicable section of this form. Review the attached job description (Employer Section, page 2, Physical/Non Physical Aspects of Job).
4. Sign and date this form after completion. Also, clearly print your name, address and phone number in the spaces provided. If applicable, include your tax number.
5. After you have completed this form, return the entire application to the claimant.

Section I - History
1. Name of Claimant:_____
2. Date of Birth: ____/____/____ 3.Social Security #_____-_____-_____
4. Patient's symptoms result from: ☐Illness ☐On-the-job accident ☐Other accident
☐Pregnancy EDC___/___/___ Delivered___/___/___
Type of Delivery_____
Date symptoms first appeared:___/___/___ Patient's Height:_____ Weight:_____
First Visit for this condition:___/___/___ Most recent visit:___/___/___
Most recent comprehensive exam:___/___/___ Follow-up exam scheduled for:____/____/____
Frequency of visits: ☐Weekly ☐Monthly ☐Other(specify)_____
Name(s) and address(es) of other treating or referring physician(s):_____
_____
_____
_____
Hospital Name:_____ Confinement dates:___/___/___ to ___/___/___

Section II - Diagnoses
Diagnoses (including any complications):_____
_____
_____
Subjective symptoms:_____
_____
_____
Objective findings (include results/copies of x-rays, lab tests, EKGs, MRIs, and scans):_____
_____
_____

(Attach relevant records appropriate to support findings - this is required by SURS law)
Section III - Treatment
Describe treatment program, including any surgery, medications, (give dates) physical therapy, or psychotherapy:_____
_____
_____

Fig. 15d

Physician Section (cont.)

State Universities Retirement System **APPLICATION FOR DISABILITY 6**

ATTENDING PHYSICIAN'S INITIAL STATEMENT OF DISABILITY (Continued)

Section IV - Psychiatric Impairment (complete only if applicable)

☐ Class 1 - Able to function under stress and engage in interpersonal relations (no limitations).
☐ Class 2 - Able to function in most stress situations and engage in only limited interpersonal relations (slight limitations).
☐ Class 3 - Able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).
☐ Class 4 - Unable to engage in stress situations or engage in interpersonal relations (marked limitations).
☐ Class 5 - Significant loss of physiological, personal and social adjustment (severe limitations).
☐ Remarks:_____

What stress and problems in interpersonal relations has claimant had on the job:_____

Do you believe a legal guardian should be appointed for this claimant? ☐**Yes** ☐**No**

Section V - Physical Impairment *As defined in the Federal Dictionary of Occupational Titles

☐ Class 1 - No limitation; capable of heavy work*
Exert 50-100# force occasionally and/or 25-50# force frequently.....No restrictions (0-10%)
☐ Class 2 - Medium activity
Exert 20-50# force occasionally and/or 10-25# force frequently.....(15%-30%)
☐ Class 3 - Slight limitation; capable of light work*
Exert up to 20# force occasionally and/or up to 10# force frequently.....(33%-55%)
☐ Class 4 - Moderate limitations; capable of sedentary*, clerical or administrative work
Exert up to 10# force occasionally, mostly sitting.....(60%-70%)
☐ Class 5 - Severe limitation; incapable of minimal activity or sedentary* work.....(75%-100%)
☐ Remarks:_____

Section VI - Cardiac

Functional Capacity (American Heart Association). Complete only if applicable.

☐ Class 1 (No limitation) ☐ Class II (Slight limitation)
☐ Class III (Marked limitation) ☐ Class IV (Complete limitation)

Fig. 15e
Physician Section (cont.)

State Universities Retirement System **APPLICATION FOR DISABILITY 7**

ATTENDING PHYSICIAN'S INITIAL STATEMENT OF DISABILITY (Continued)

Section VII - Work Capabilities

Doctor: Check if you have reviewed the: ☐Job Description

Fully describe how claimant's symptoms/limitations affect ability to work, e.g. how work schedule/duties are restricted and why?_____

_____

_____

_____

_____

Section VIII - Prognosis

Prognosis (check one): ☐Terminal ☐Poor ☐Good ☐Excellent
Would any further therapy be reasonably expected to result in full or partial recovery?
☐Yes(describe below) When____/____/____ ☐No ☐Unknown

_____

_____

Has claimant reached maximum medical improvement?
☐**Yes** ☐**No** If "No" When____/____/____ ☐Unknown
Is claimant released to return to duty? ☐**Yes** ☐**No** ☐Restrictions (list)_____

_____

_____

Section IX - Rehabilitation

Is claimant a candidate for rehabilitation services? ☐**Yes** (describe) ☐**No** (explain)

_____

Would job modification enable claimant to work with impairment? ☐**Yes** (describe)☐**No**(explain)

_____

Section X - Physician Information

_____ _____

(Physician's Signature) **(Please Print Physician's Name Here)**

_____ _____

(Street Address) **(Degree/Speciality)**

_____ _____

(City, State, Zip Code) **(EIN or SSN)**

_____ _____

(Telephone) **(Fax)**

_____

(Date - do not predate)

2. Report of Earnings

An employee who has been released by the physician may return to work part-time. Disability payments will be reduced by the amount of earnings in excess of the amount of the disability benefit. If it appears that the earnings will indeed exceed the benefit, SURS will send the employee a supply of Verification of Earnings Forms along with a letter explaining the procedure they must follow in order to receive the monthly check**.** (Fig. 16)

The disability benefit will be put on hold until the employee sends SURS his/her report of earnings. All disability recipients (except those on a monthly hold due to exceeding their disability amount) are required to complete the Earnings Card which is sent to them every four months.

Fig. 16

Barbara Denison
333-42-9127

In order to issue your disability benefits, the State Universities Retirement System (SURS) requires verification of what you have earned within that month. This information must be reported by month and not by payroll period. Please provide the number of hours and the rate of pay in the appropriate box in order to receive any disability benefits you may be eligible for that month. Please Note: SURS must have your supervisor or payroll clerk's approval to process your benefits.

JANUARY 1-31	FEBRUARY 1-28	MARCH 1-31	APRIL 1-30
TOTAL HOURS:	TOTAL HOURS:	TOTAL HOURS:	TOTAL HOURS:
HOURLY RATE:	HOURLY RATE:	HOURLY RATE:	HOURLY RATE:
MAY 1-31	**JUNE 1-30**	**JULY 1-31**	**AUGUST 1-31**
TOTAL HOURS:	TOTAL HOURS:	TOTAL HOURS:	TOTAL HOURS:
HOURLY RATE:	HOURLY RATE:	HOURLY RATE:	HOURLY RATE:
SEPTEMBER 1-30	**OCTOBER 1-31**	**NOVEMBER 1-30**	**DECEMBER 1-31**
TOTAL HOURS:	TOTAL HOURS:	TOTAL HOURS:	TOTAL HOURS:
HOURLY RATE:	HOURLY RATE:	HOURLY RATE:	HOURLY RATE:

I certify that the information reported on this form is accurate; if I have more than one source of income, I am supplying a copy of this form for each individual employer.

EMPLOYEE SIGNATURE _____ DATE _____

PLACE OF EMPLOYMENT _____

SIGNATURE OF SUPERVISOR OR PAYROLL CLERK _____ DATE _____

SUPERVISOR OR PAYROLL CLERK (PLEASE PRINT) _____ PHONE NUMBER _____

TO ENSURE TIMELY PROCESSING FAX THIS COMPLETED DOCUMENT TO: **217/378-9806**

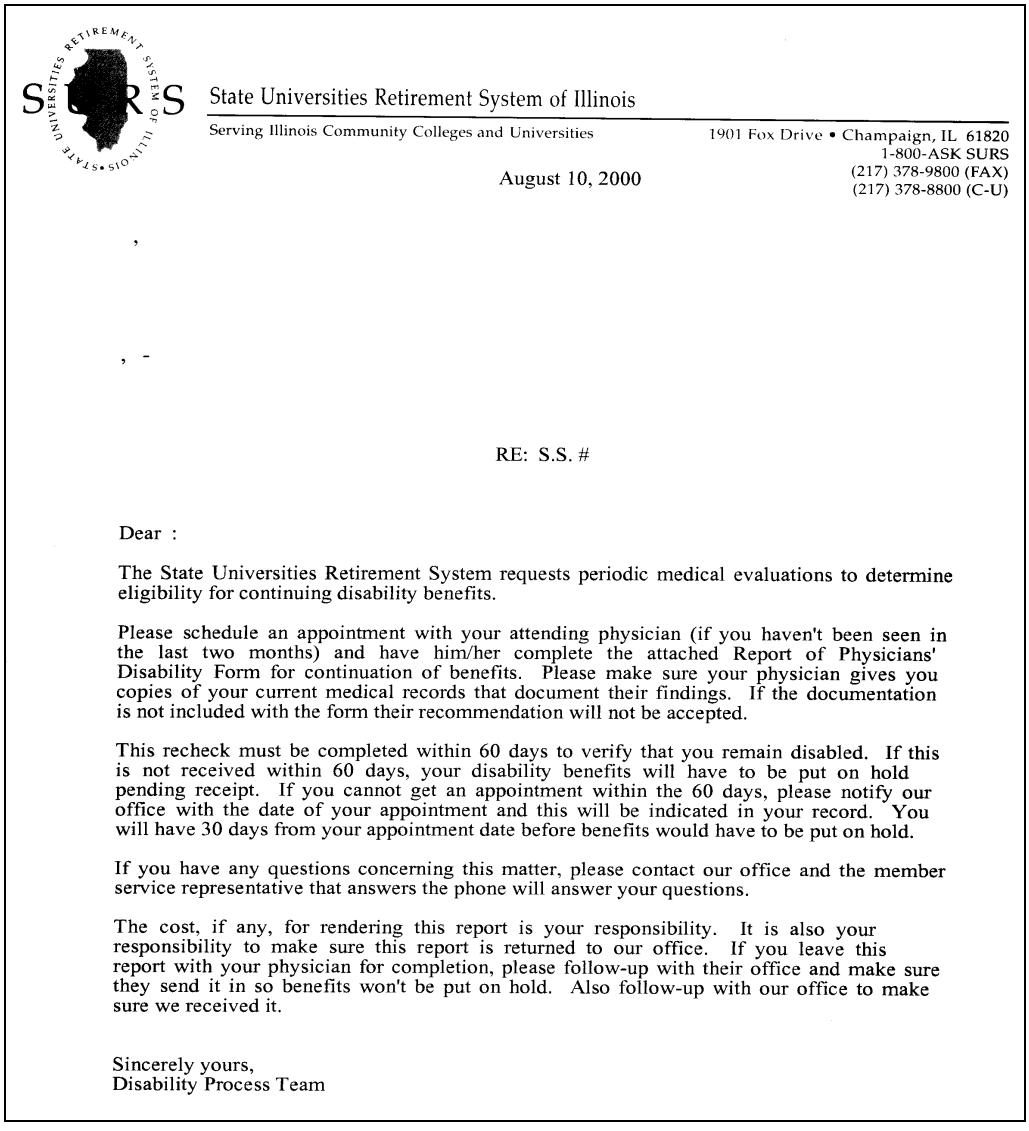
6/15/00

3. Recheck Report

Employees on disability must periodically submit evidence of their disability. The recheck dates vary according to the employee's disability. SURS will contact each employee on issues of rechecks and inform him/her what needs to be done. (Fig. 17)

Fig. 17a

Recheck Report (Page 1)



State Universities Retirement System of Illinois

Serving Illinois Community Colleges and Universities

1901 Fox Drive • Champaign, IL 61820
1-800-ASK SURS
(217) 378-9800 (FAX)
(217) 378-8800 (C-U)

August 10, 2000

,

, -

RE: S.S. #

Dear :

The State Universities Retirement System requests periodic medical evaluations to determine eligibility for continuing disability benefits.

Please schedule an appointment with your attending physician (if you haven't been seen in the last two months) and have him/her complete the attached Report of Physicians' Disability Form for continuation of benefits. Please make sure your physician gives you copies of your current medical records that document their findings. If the documentation is not included with the form their recommendation will not be accepted.

This recheck must be completed within 60 days to verify that you remain disabled. If this is not received within 60 days, your disability benefits will have to be put on hold pending receipt. If you cannot get an appointment within the 60 days, please notify our office with the date of your appointment and this will be indicated in your record. You will have 30 days from your appointment date before benefits would have to be put on hold.

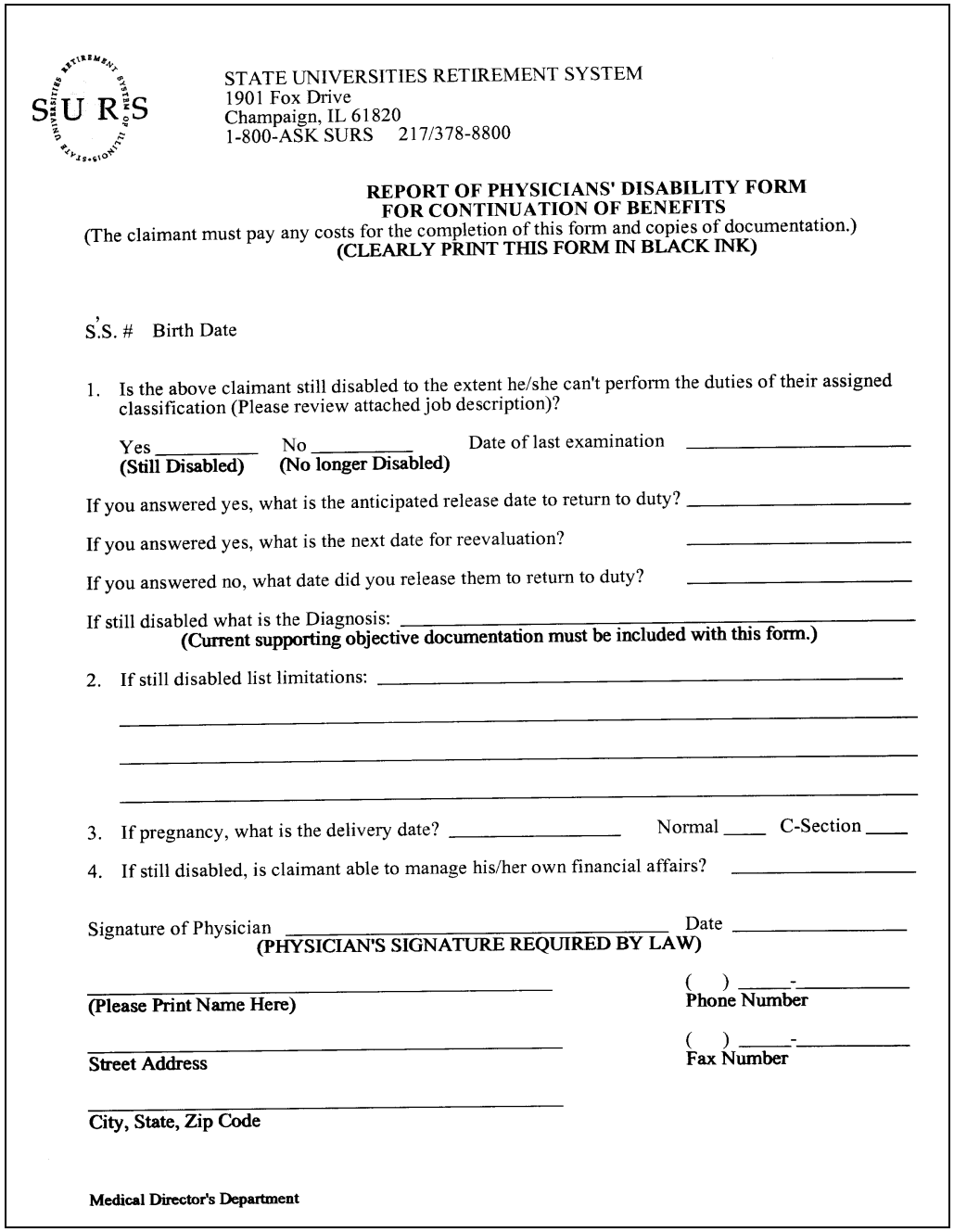
If you have any questions concerning this matter, please contact our office and the member service representative that answers the phone will answer your questions.

The cost, if any, for rendering this report is your responsibility. It is also your responsibility to make sure this report is returned to our office. If you leave this report with your physician for completion, please follow-up with their office and make sure they send it in so benefits won't be put on hold. Also follow-up with our office to make sure we received it.

Sincerely yours,
Disability Process Team

Fig. 17b

Recheck Report (Page 2)



STATE UNIVERSITIES RETIREMENT SYSTEM
1901 Fox Drive
Champaign, IL 61820
1-800-ASK SURS 217/378-8800

REPORT OF PHYSICIANS' DISABILITY FORM FOR CONTINUATION OF BENEFITS

(The claimant must pay any costs for the completion of this form and copies of documentation.)
(CLEARLY PRINT THIS FORM IN BLACK INK)

S.S. # Birth Date

1. Is the above claimant still disabled to the extent he/she can't perform the duties of their assigned classification (Please review attached job description)?

   Yes _____ No _____ Date of last examination _____
   (Still Disabled) **(No longer Disabled)**

If you answered yes, what is the anticipated release date to return to duty? _____

If you answered yes, what is the next date for reevaluation? _____

If you answered no, what date did you release them to return to duty? _____

If still disabled what is the Diagnosis: _____
(Current supporting objective documentation must be included with this form.)

2. If still disabled list limitations: _____

3. If pregnancy, what is the delivery date? _____ Normal ____ C-Section ____

4. If still disabled, is claimant able to manage his/her own financial affairs? _____

Signature of Physician _____ Date _____
(PHYSICIAN'S SIGNATURE REQUIRED BY LAW)

_____ ( ) _____-_____
(Please Print Name Here) **Phone Number**

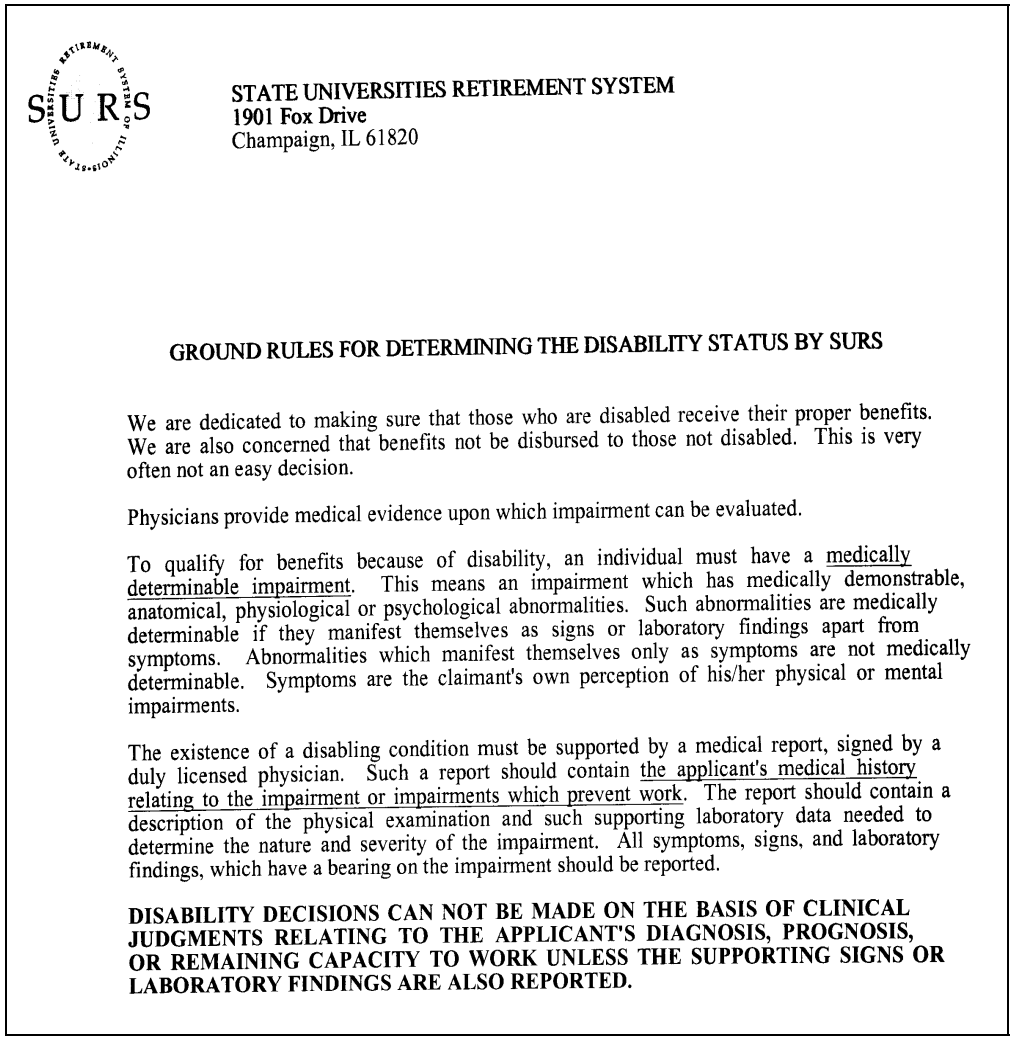
_____ ( ) _____-_____
Street Address **Fax Number**

_____
City, State, Zip Code

Medical Director's Department

Fig. 17c

Recheck Report (Page 3)



STATE UNIVERSITIES RETIREMENT SYSTEM
1901 Fox Drive
Champaign, IL 61820

GROUND RULES FOR DETERMINING THE DISABILITY STATUS BY SURS

We are dedicated to making sure that those who are disabled receive their proper benefits. We are also concerned that benefits not be disbursed to those not disabled. This is very often not an easy decision.

Physicians provide medical evidence upon which impairment can be evaluated.

To qualify for benefits because of disability, an individual must have a medically determinable impairment. This means an impairment which has medically demonstrable, anatomical, physiological or psychological abnormalities. Such abnormalities are medically determinable if they manifest themselves as signs or laboratory findings apart from symptoms. Abnormalities which manifest themselves only as symptoms are not medically determinable. Symptoms are the claimant's own perception of his/her physical or mental impairments.

The existence of a disabling condition must be supported by a medical report, signed by a duly licensed physician. Such a report should contain the applicant's medical history relating to the impairment or impairments which prevent work. The report should contain a description of the physical examination and such supporting laboratory data needed to determine the nature and severity of the impairment. All symptoms, signs, and laboratory findings, which have a bearing on the impairment should be reported.

DISABILITY DECISIONS CAN NOT BE MADE ON THE BASIS OF CLINICAL JUDGMENTS RELATING TO THE APPLICANT'S DIAGNOSIS, PROGNOSIS, OR REMAINING CAPACITY TO WORK UNLESS THE SUPPORTING SIGNS OR LABORATORY FINDINGS ARE ALSO REPORTED.

SURS's Responsibilities

When SURS receives the completed application, the employee's file will be directed to a Disability Process Team Member. If any information is missing or not completed correctly, SURS will contact the employee or employer (depending on the type of information required).

If member is inelligible (less that two years service credit and not an accident, returned to duty before sixty day period expired, or before they are off the payroll) the member and employer will be sent a letter.

When all requested information has been received and verified the Disability Process Team Member will review the medical documentation and determine, based on this information, whether the member is disabled or not.

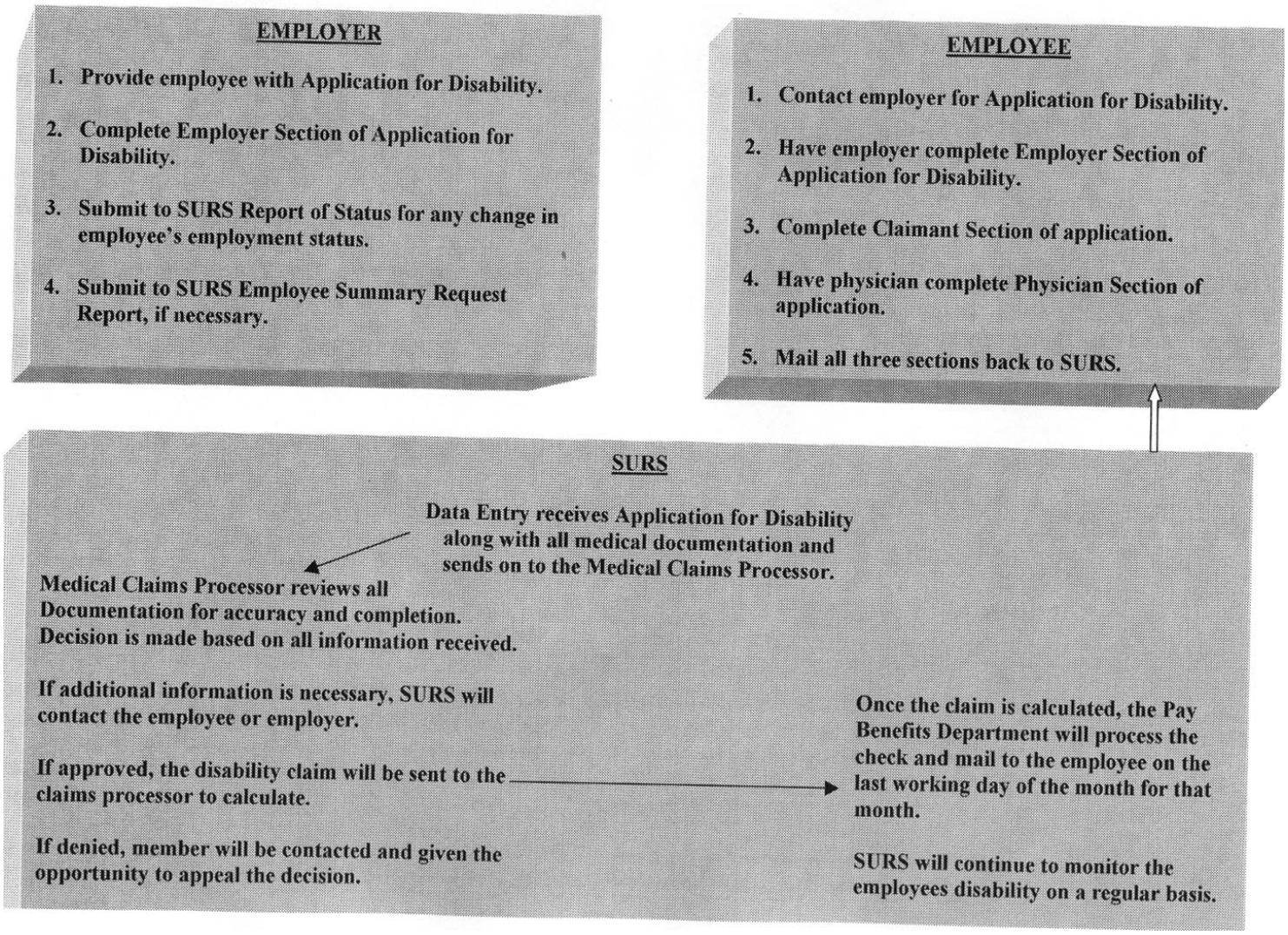
If the disability is medically **approved,** the claim will be sent to a Member Service Representative to calculate. The claim can then be processed if all employer information has been received (Employer Summary Report, last payroll posted, etc.). It is then forwarded to the Pay Benefits Department for payment. SURS will send the employee an Awards Letter outlining the amount of benefit, duration of payment, and the date a recheck may be requested. **No action can be taken on a claim as long as the employee remains on payroll.**

SURS will pay the disability benefit on the last working day of the month and is responsible to pay disabled employees accurately and on a timely basis.

If the disability claim is **denied,** SURS will inform the employee and employer in writing and provide instructions as to what steps to take if the employee disagrees with the decision.

It is also SURS's responsibility to monitor and recheck all disability claims on a regular basis. A letter of notification will be sent to the employee when a recheck is being requested and the results of the recheck will be sent to the employee and employer.

DISABILITY PROCESS



Additional Information

1. The disability benefit and application process is the same under the Traditional, Portable, and Self-Managed Plans.

2. Employees receiving disability payments will continue to earn service credit.

3. SURS will administer the insurance benefits for employees on disability from a State agency only. Disability recipients who have been certified at a 100% employment status will be the only ones eligible for insurance benefits through SURS.

   SURS does not administer the insurance benefits for disability recipients from a Community College.

   Each school will administer the insurance for its employees on disability for the first 6 months. After that, SURS will administer all insurance benefits. All employers will be notified as to when the transfer of insurance will occur.

   SURS will not take over any insurance files from Central Management Services that have discrepancies. Once a discrepant file has been resolved, however, SURS will accept the transfer of that file.