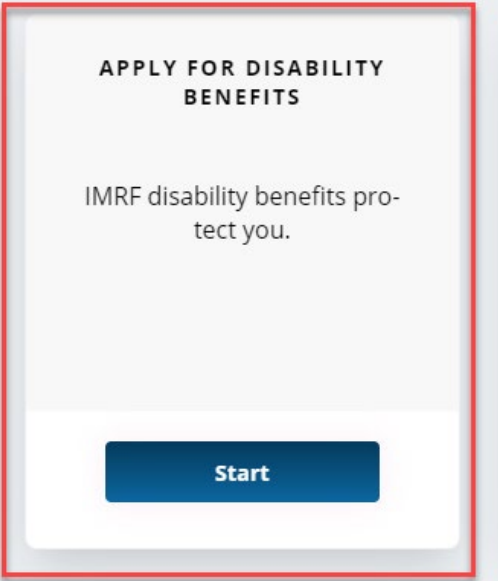


Member Access – How to Apply for Disability Benefits



Locally funded, financially sound.



Image	Description
	<p>Click “Start” on the Apply for Disability Benefits widget under Online Tools.</p>
<p>Disclaimer</p> <p>If you expect to be disabled for more than 30 days and you have stopped working for your employer, you may use this tool to apply for IMRF disability benefits.</p> <p>Before submitting your application, visit www.imrf.org to learn about the disability benefits process. Also, make sure that your personal information on file with IMRF is accurate.</p> <p>Any information you enter will be saved in the tool, which means that you can exit at any time and return later to complete the request.</p> <p><input type="checkbox"/> I understand and agree with the terms of the disclaimer.</p> <p>Continue</p> <p>If you have any questions, please call IMRF Member Services at 1-800-ASK-IMRF (275-4673).</p>	<p>Read the disclaimer.</p> <p>Click the box to add a checkmark next to “I understand and agree with the terms of the disclaimer”.</p> <p>Click “continue”.</p>

My Information

Please review the information below. If it is incorrect or incomplete, click **Update** and edit the information.

My Personal Information

Full Name [Redacted]	Prior Last Name Not on file
Date of Birth [Redacted]	

[Update](#)

My Contact Information

Residential Address [Redacted]	Mailing Address Same address as residential
Email Address [Redacted]	
Residential Phone Number [Redacted]	Mobile Phone Number [Redacted]

[Update](#)

Review your information and if any changes are needed, click “update”.

My Communication Preferences

Preferred Language
Benefit plan communications
English

Delivery Method

Tax Slips Paper and Electronic Versions	Other Documents Electronic Version Only
---	---

Subscriptions

IMRF Fundamentals Newsletter Subscribed	Survey Subscription Subscribed
---	--

Allow Mailings from Outside Groups
Subscribed

Notification Preferences

Notice of Change	<input checked="" type="checkbox"/> Email
New Document on Portal	<input checked="" type="checkbox"/> Email

Email Address
[Redacted]

[Update](#)

Review your communication preferences and if any changes are needed, click “update”.

Click “next” to continue the application.

- ✓ My Information — 2 My Last Day of Work — 3 My Illness or Injury — 4 My Employment Status
— 5 My Banking Information — 6 My Tax Withholding Election — 7 Review — 8 Confirmation

My Last Day of Work

My Last Day of Work ①

Please enter the date of your last day at work.

04-06-2023



Previous

Next

Enter your last day of work and click "next".

My Illness or Injury

Please provide the required information below.

① Details

What is your illness or injury?

Date of First Treatment for this Illness or Injury

04-06-2023



Are you claiming disability benefits because of a pregnancy?

Yes

No

Did you visit an emergency room or urgent care facility?

Yes

No

Was your injury caused by an accident?

Yes

No

In the past six months, have you been off work for the same illness or injury?

Yes

No

Have you filed a workers' compensation and/or occupational disease claim?

Yes

No

Complete the details section.

② **Physicians Consulted**

Name and address of **all** physicians consulted and dates of consultation.

Click **Add** to add a physician you have consulted.


Add +

Click "Add+" in the Physicians Consulted section to add a physician you have consulted.

Physician Consulted ✕

Name of Doctor

Consultation Date

Phone Number

Address

City

Zip Code

E.g. A1A 1A1, 12345 or 12345-6789

Country

[Cancel](#)

Save

Complete the fields with the physician' information then click "save".

3 Hospitals Where You Were Treated

Name and address of **all** hospitals where you were treated, including emergency room or urgent care facility.

Click **Add** to add a hospital where you were treated.

Add +

Click "Add+" in the hospitals where you were treated section to add a hospital or urgent care facility you were treated at.

Previous

Next

Hospital Where You Were Treated X

Name of Hospital

Date of Treatment

MM-DD-YYYY



Phone Number

Address

City

Zip Code

E.g. A1A 1A1, 12345 or 12345-6789

Country

Select



Cancel

Save

Complete the fields with the hospital or urgent care facility information then click "save".

My Employment Status

Please provide the required information below.

Employment Status Details

Are you currently employed by an employer other than those listed below?

- [Redacted]

Yes No

Do you own your own business?

Yes No

Do you perform any work or other activities that you are paid for?

Yes No

Previous

Next

Provide the required information regarding your employment status and click "next".

My Banking Information

By Direct Deposit

Update

Please review the information below. If it is incorrect or incomplete, click **Update** and edit the information.

ⓘ You must provide your banking information before proceeding to the next step.

Previous

Next

Click "update" to add your banking information.

1 Update

2 Review

3 Confirmation

Update my banking information

Update the following information to change where your pension payment is deposited.

Direct deposit information ⓘ

Account Type
 Checking Savings

Routing Number (9 digits)

[Redacted] ⓘ

Account Number (5 to 15 digits)

[Redacted] ⓘ

Confirm Account Number

[Redacted] ⓘ

Sample check

[Redacted] ⓘ

⑆ 23456789 ⑆ ⑆ 23456789 ⑆ ⑆ ⑆

ⓘ Your banking information changes may not take effect until after your next benefit payment.

Cancel

Next

Select your bank account type and enter the routing and account numbers.

Click "next".

Update

2 Review

3 Confirmation

Review

Please review and confirm the following information.

Account Type	Checking
Routing Number	[Redacted]
Account Number	[Redacted]

Previous Confirm

Review the information for accuracy.

Click "previous" to go back and make an edit or click "confirm" to submit.

Confirmation

Changes successfully submitted

Your confirmation number is

[Redacted]

Your changes were requested on

April 7, 2023

Your banking information changes may not take effect until after your next benefit payment.

Additional Actions

View a printer-friendly version of your confirmation

Printable Version

Close

Click "printable version" to download and print your banking information confirmation or click "close".

My Information My Last Day of Work My Illness or Injury My Employment Status My Banking Information My Tax Withholding Election Review Confirmation

My Tax Withholding Election

Update

Please review the information below. If it is incorrect or incomplete, click Update and edit the information.

Federal Taxes	
Filing Status	Single
Income	
Total	\$0
Credits	
Total	\$0
Other Adjustments	
Extra Withholding	\$0
Deductions	\$0
Other Income	\$0

Since you have not provided tax withholding instructions, IMRF will apply the IRS tax tables to your benefit as indicated above.

Previous Next

Click "update" to update your federal tax withholding instructions or click "next" to use IMRF's default instructions.

- ✔ My Information
- ✔ My Last Day of Work
- ✔ My Illness or Injury
- ✔ My Employment Status
- ✔ My Banking Information
- ✔ My Tax Withholding Election
- 7 Review**
- 8 Confirmation

Review your application entries for accuracy.

Review

Please verify the information below and click **Submit** to submit your application.

My Information

My Personal Information

Full Name

[Redacted]

Prior Last Name

Not on file

Date of Birth

[Redacted]

My Contact Information

Residential Address

[Redacted]

Mailing Address

Same address as residential

Email Address

[Redacted]

Residential Phone Number

[Redacted]

Mobile Phone Number

[Redacted]

My Communication Preferences

Preferred Language

Benefit plan communications

English

Delivery Method

Tax Slips

Paper and Electronic Versions

Other Documents

Electronic Version Only

Subscriptions

IMRF Fundamentals Newsletter

Subscribed

Survey Subscription

Subscribed

Allow Mailings from Outside Groups

Subscribed

Notification Preferences

Notice of Change

✉ Email

New Document on Portal

✉ Email

Email Address

[Redacted]

My Last Day of Work

My Last Day of Work

April 6, 2023

My Illness or Injury


Details

What is your illness or injury?

Date of First Treatment for my Illness or Injury
April 6, 2023

Are you claiming disability benefits because of a pregnancy?
No, I am not claiming disability benefits because of a pregnancy.

Did you visit an emergency room or urgent care facility?
Yes, I have visited an emergency room or urgent care facility.

 You will have to provide a discharge summary from the emergency room or urgent care facility.




Was your injury caused by an accident?
Yes, my injury was caused by an accident.

In the past six months, have you been off work for the same illness or injury?
Yes, I have been off work for the same injury or illness.

Have you filed a workers' compensation and/or occupational disease claim?
No, I have not filed a workers' compensation and/or occupational disease claim.




Physicians Consulted

Below is the list of physicians I have consulted:

Name of Doctor	Contact Information	Date of Consultation
	 Phone Number  Address	Apr 6, 2023

Hospitals Where You Were Treated

Below is the list of hospitals where I was treated:

Name of Hospital	Contact Information	Date of Treatment
	 Phone Number  Address	Apr 6, 2023

My Employment Status

Employment Status Details

Are you currently employed by an employer other than those listed below?

- [Redacted]

No, I am not currently employed by another employer.

Do you own your own business?

No, I am not the owner of my own business.

Do you perform any work or other activities that you are paid for?

No, I do not perform work or other activities for which I am paid.

My Banking Information

🕒 You currently have changes being processed.

My Tax Withholding Election

Federal Taxes

Filing Status

Single

Income

Total \$0

Credits

Total \$0

Other Adjustments

Extra Withholding \$0

Deductions \$0

Other Income \$0

🕒 Since you have not provided tax withholding instructions, IMRF will apply the IRS tax tables to your benefit as indicated above.

Certification

I, [Redacted] confirm that the above information is accurate. By clicking on "I agree", I am providing my electronic signature and making an electronic request that processing of my request to receive disability benefits begins. I understand that my electronic signature is legally binding with the same force and effect as a manually executed signature. I also understand that my employer will be informed of my request.

I agree

Previous

Submit

If your application needs to be edited, click "previous".

If you are ready to submit your application to IMRF, click the box next to "I agree" in the certification section.

Click "submit".

Confirmation

Additional Actions

View a printer-friendly version of your confirmation

Printable Version

Required Document

To prevent delays, please provide the following document:

Discharge summary from emergency room or urgent care facility
Employer's Statement
Disability Claim
Physician's Statement
Disability Claim

✓ Application submitted successfully

Your Confirmation Number is



Your application was submitted on

April 7, 2023

🔔 We will review your application and contact you if additional information is required.

Close

Click "printable version" to download and print your application confirmation if needed.

Click "close".

HOME Helpful Resources

MY IMRF

ACTIVITY HISTORY
Last 30 days
Application for Disability Benefits
In Progress
Submitted: Apr 7, 2023
Last Update: Apr 7, 2023

REQUEST FOR INFORMATION
Your file contains no request for information.
Details

Pension Profile

Documents

In the Activity History widget on your Member Access homepage, you will see your Application for Disability Benefits is In Progress.