Application for IMRF Disability Benefits

IMRF Form 5.40 (Rev. 10/2009)

Please use this checklist when applying for IMRF disability benefits.

As soon as you stop working and you feel you will be disabled more than 30 days. . .

1. File an **Application for Disability Benefits** (IMRF Form 5.40) with IMRF. We recommend you submit your application **directly to IMRF**.
   - You can also **fax** your application to IMRF at **630-706-4289.**
   - File the form even if you filed a worker's compensation claim.
   - Print your Social Security number on all documents you enclose with the form.

☐ MAILED
☐ FAXED

____
DATE YOU FILED

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2. Call your employer and ask them to file an **Employer's Statement** with IMRF (IMRF Form 5.41). Your employer should have the form. If not, they can download the form from www.imrf.org.
   - Write down the name of the person you spoke with and the date.
   - Ask when the employer thinks the form will be submitted to IMRF.

____
PERSON YOU SPOKE WITH

____
DATE

____
DATE EMPLOYER WILL SUBMIT

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3. Provide your physician(s) (the **first** physician who examined you for this disabling condition) with a **Physician's Statement of Disability Claim** (IMRF Form 5.42) and have your physician(s) submit the documentation to IMRF, **with copies of your medical records from the date of disability.**
   - Write down the name of the person you spoke with and the date.
   - Ask when the physician(s) will complete the form and submit it to IMRF.

____
PERSON YOU SPOKE WITH

____
DATE

____
DATE PHYSICIAN WILL SUBMIT

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4. IMRF will acknowledge receipt of your claim in writing. Call IMRF at 1-800-ASK-IMRF (1-800-275-4673) if you have not heard anything within 10 business days after the date of your acknowledgement letter. IMRF will request additional medical information, if needed, directly from your medical providers (you will receive a copy of any such request).

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5. When IMRF receives any of the above three forms, we will mail you an acknowledgment letter and an IMRF Disability Benefits booklet. We will also request any missing forms.

See the reverse side of this checklist for instructions on how to complete the attached form.

PLEASE NOTE:

- **You should contact IMRF if you are considering RESIGNING from your current position. Resigning your position may impact your eligibility for IMRF disability benefits.**

- **Please be advised that IMRF disability payments are paid at the beginning of the month for the previous month.**

Illinois Municipal Retirement Fund
2211 York Road, Suite 500, Oak Brook Illinois 60523-2337
Member Services Representatives PH 1-800-ASK-IMRF (1-800-275-4673) ● FX 630-706-4289 ● *www.imrf.org*

Who does what in this process?

- **You** need to print **your Social Security number** on all documents you send to IMRF (e.g., your birth certificate).
- Your **employer** needs to file an Employer's Certificate of Disability (IMRF Form 5.41).
- **Your physician(s)** needs to file a Physician's Statement of Disability (IMRF Form 5.42). **You** must provide the physician(s) with the form.
- If your doctor releases you to return to work on a part-time basis, **you** should refer to "Trial Work Period" in the IMRF Disability Benefits booklet.

Instructions for completing Questions 1 - 11

Q 1A, 1B, 1C Enter the requested information. **If you do not answer** question 1B, you will **delay processing** of your claim. If appropriate, answer question 1C.

Q 2 Enter the last date you worked. **Do not file this claim if you are still working.** If you will be disabled due to a planned event (e.g., elective surgery, pregnancy), submit this form **after your last day at work. If you do not answer** question 2, you will **delay processing** of your claim.

Q 3A, 3B, 3C If appropriate, enter the requested information.

Q 4 Answer either yes or no.

Q 5 Answer yes or no and, if appropriate, enter the requested information.

Q 6 Answer either yes or no, and, if appropriate, indicate status of claim.

Q 7 Answer either yes or no.

Q 8 Answer yes or no and, if appropriate, enter the requested information.

Q 9 Answer yes or no and, if appropriate, enter the requested information.

Q 10 Enter the name, address, and phone number of each doctor you saw and the date of each visit.

Q 11 Enter the name, address, phone number, and dates of treatments for each hospital in which you were treated.

Question 12 - W-4P Federal Income Tax Withholding Certificate information

This question serves as a substitute IRS Form W-4P.

IMRF disability benefits are subject to federal income tax. IMRF must withhold income tax unless you elect on line 12a not to have tax withheld.

If you elect to have income tax withheld, complete line 12b. If you complete line 12b and also want an additional amount withheld from your monthly disability benefit payments, enter this amount on line 12c.

CAUTION: Remember that there are penalties for not paying enough tax during the year. For more information, please see IRS Publication 505, "Tax Withholding and Estimated Tax," available from most IRS offices or from www.irs.gov.

- You may use IRS Form W-4P in lieu of Question 12. Form W-4P is available at most IRS offices.

Purpose

Unless you elect otherwise, federal income tax will be withheld from your disability benefit. The law requires that unless you tell IMRF otherwise, tax will be withheld on IMRF monthly payments as if you are married and claiming three withholding allowances. To view the tax amount to be withheld under current regulations, please visit www.imrf.org and view "Tax Letter #13" under "Publications."

You can use this certificate (Question 12) to instruct IMRF to do any of the following:

- To withhold no tax from your disability payments.
- To withhold taxes based on the number of allowances and marital status you indicate.
- To withhold an additional amount you specify from each payment.

Your tax withholding instruction stays in effect until you change or revoke it. IMRF must notify you each year of your right to elect to have no tax withheld or to revoke your election.

Statement of income tax withheld from your disability payments

By January 31 of next year, you will receive a statement (1099-R) from IMRF showing the total amount of your disability payments and the total income tax withheld during the year. Any IMRF disability payments you receive will be subject to federal income tax, but not to Illinois state income tax. If you are a resident of another state, please check with your state's Department of Revenue to learn whether you will pay that state's income tax on IMRF disability benefits.

If you are totally and permanently disabled, you may be eligible for a tax credit. For additional information about the tax credit, you can call 1-800-TAX-FORM (1-800-829-3676) and request IRS publication 524 "Credit for the Elderly or the Disabled," or contact a tax advisor.

MEMBER'S APPLICATION FOR DISABILITY BENEFITS

IMRF Form 5.40 (Rev. 10/2009) ***Please Print or Type – Use Black Ink***

Member's Last Name	First	Middle Initial	Social Security Number _______ - _____ - _______
Street (Mailing) Address	City, State and ZIP		Telephone: ( ) ________ Cell Phone: ( ) ________ Email: ________

FILING GUIDELINES

- **Do not file this claim if you are still working.**
- **If you will be disabled due to a planned event (e.g., elective surgery, pregnancy), submit this form after your last day at work.**
- You should file this application **if you expect to be disabled for more than 30 days.**
- File this form even if you plan to file a workers' compensation and/or occupational disease claim.

ATTACHMENT GUIDELINES

- A copy of your **birth certificate** should be filed with this application. If that form is delayed, file this application without it.
- **Please print your Social Security number on all documents you enclose with this form.**

IF YOU RETURN TO WORK ON A PART-TIME BASIS

- Refer to **"Trial Work Period"** in the IMRF Disability Benefits booklet.

1A. Nature of illness or injury ____________________

1B. Date of first treatment for this disability (i.e., date of first doctor visit) ____________________

1C. If claiming disability benefits because of pregnancy, expected or actual date of delivery ____________________

2. Date you last worked ____________________

3A. If accident, date accident occurred ____________________

3B. How and where accident happened ____________________

3C. Did you visit an emergency room or Urgent Care facility?
No ☐ Yes ☐
If yes, attach copy of Discharge Summary.

4. Within the past six months, have you been off work for the same injury or illness?
No ☐ Yes ☐

5. Has your disability ended?
No ☐
Yes ☐ Date ____________________

6. Are you applying for workers' compensation and/or occupational disease benefits?
No ☐ Yes ☐
Status of claim *(check one)***:**
Approved ☐ Pending ☐
Denied ☐ Appealed ☐

7. Have you participated in the IMRF Elected County Officials Plan (ECO)?
No ☐ Yes ☐

8. Are you currently employed by an employer outside IMRF?
No ☐ Yes ☐ If yes, give name, address and telephone of employer
____
____
____

9. Do you own a business? No ☐ Yes ☐
If yes, do you work for the business? No ☐ Yes ☐
If yes, give name, address and telephone of business
____
____
____

10. Name and address of all physicians consulted and date of consultation
(Attach additional sheet if needed. Each physician needs to complete IMRF Form 5.42, Physician's Statement)

Name of doctor	Phone	Address	City/State/Zip	Date of Consultation

11. Name and address of all hospitals where you were treated, including facility from question 3C (Attach additional sheet if needed.)

Name of hospital	Phone	Address	City/State/Zip	Date of Consultation

12. Form W-4P Federal Income Tax Withholding Certificate (substitute form)—Complete the following applicable lines:

12a. I elect to have no income tax withheld from my disability payments. (Do not complete lines 12b or 12c.)...☐

12b. I want my withholding from each periodic disability payment to be calculated using the number of allowances and marital status shown. (You may also designate an amount on line 12c.) .... ____________ (number of allowances)
☐ Single ☐ Married ☐ Married, but withheld at higher single rate

12c. I want the following additional amount withheld from each periodic disability payment. ....$___________

To all employers, insurance companies, workers' compensation carriers and all other agencies:

I authorize the Illinois Municipal Retirement Fund, or its representatives, to obtain or view a copy of all employment records, and/or workers' compensation records. A photostatic copy of this authorization shall be considered as effective and valid as the original. **Do not complete prior to your last day of work.**

Signature **X** ______________________________ Date ________________

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