



APPLICATION TO SERVE AS REPRESENTATIVE PAYEE FOR ANNUITANT

IMRF Form 5.60 (Rev. 07/11)

PLEASE PRINT OR TYPE - USE BLACK INK

INSTRUCTIONS

- This application is to be submitted by a person who has assumed the responsibility for the care of an IMRF annuitant who is physically unable to sign his or her check or is mentally incompetent to handle his or her own affairs.
- A representative payee may be a spouse or child, or other family member upon approval.
- Proof of the relationship is required along with this application. The following forms of proof are needed:
 - Spouse - a copy of the marriage/civil union certificate
 - Child - a copy of the child's birth certificate
 - Other family member - please contact IMRF at 1-800-275-4673 and ask for the Treasury Unit to discuss what steps are necessary for approval.
- **Annuity payments must be used solely for the use and benefit of the annuitant.**

SECTION 1 — IMRF ANNUITANT AND REPRESENTATIVE PAYEE INFORMATION

IMRF ANNUITANT'S FIRST NAME	MIDDLE INITIAL	LAST	JR., SR., II, ETC.	ANNUITANT'S SOCIAL SECURITY NUMBER
				_____ - _____ - _____
REP. PAYEE'S FIRST NAME	MIDDLE INITIAL	LAST	JR., SR. II, ETC.	REP. PAYEE'S SOCIAL SECURITY NUMBER
				_____ - _____ - _____
REP. PAYEE'S STREET ADDRESS	CITY	STATE	ZIP CODE +4	RELATIONSHIP TO IMRF ANNUITANT
Is the annuitant in a hospital, nursing home or institution?				REP. PAYEE'S DAYTIME PHONE NUMBER
<input type="checkbox"/> YES <input type="checkbox"/> NO				
If the answer is YES, give name and address of facility:				
<p>I hereby certify that I have assumed the responsibility for the care of the annuitant who is unable to use these benefits in his/her own interest and I will use the proceeds of the IMRF annuity checks solely for the use and benefit of the annuitant. I agree, if requested by the Board of Trustees, to submit a report to IMRF stating the manner in which such annuity was used, and to immediately notify IMRF in the event of the annuitant's death. This application must be renewed each year and the physician's statement every three years.</p>				
SIGNATURE OF REPRESENTATIVE PAYEE				DATE (MM/DD/YY)
X				

SECTION 2 — PHYSICIAN'S STATEMENT

PHYSICIAN'S NAME (PLEASE PRINT)	PHONE (INCLUDE AREA CODE)
STREET (MAILING) ADDRESS	CITY
STATE AND ZIP (+4 IF KNOWN)	
Diagnosis of present condition	
How long has this condition existed?	How long has the patient been under your care?
When did you last examine the patient?	Prognosis:
I hereby certify that the above statements and answers are true to my best information, knowledge and belief.	
SIGNATURE OF PHYSICIAN	TITLE
X	
DATE (MM/DD/YY)	

Illinois Municipal Retirement Fund
 Suite 500 2211 York Road Oak Brook, IL 60523-2337
 Member Services Representatives 1-800-ASK IMRF (1-800-275-4673)
www.imrf.org