maine PERS Public Employees Retirement System
P.O. Box 349
Augusta, ME 04332-0349
Telephone: (207) 512-3100
Toll-free: 1-800-451-9800
Fax: (207 512-3285
TTY: (207) 512-3102

FORM 1 (Recipient to Complete)

REPORT OF CONTINUING DISABILITY

Recipient Name: _____ (Prefix) _____ (First) _____ (MI) _____ (Last) _____ (Suffix)

Mailing Address: _____ (PO Box/Street Address) _____ (City) _____ (State) _____ (ZIP)

Last Four Digits of Social Security Number: _____ Daytime Telephone #: _____

1. List the condition(s) for which you were granted MainePERS disability benefits:_____

_____

2. What symptoms are you currently experiencing? _____

_____

_____

_____

_____

3. What are you unable to do as a result of these symptoms? _____

_____

4. List the name, address and telephone number for providers who have treated you for this condition(s) in the last 12 - 18 months:

1. _____ (Name) _____ (Address) _____ (Telephone Number)
2. _____ (Name) _____ (Address) _____ (Telephone Number)
3. _____ (Name) _____ (Address) _____ (Telephone Number)
4. _____ (Name) _____ (Address) _____ (Telephone Number)

5. Have you engaged in any work activity since your retirement?: ❑ Yes ❑ No

If "Yes": number of hours worked per week _____

amount of hourly pay $_____

dates of employment _____

What are/were your duties? _____

Place of Employment: _____

If no longer working, when and why did you leave? _____

6. Are you receiving any of the following?:

Workers' Compensation: ❑ Yes ❑ No Social Security Disability Benefits: ❑ Yes ❑ No

If "Yes," to either of the above, amount received monthly $_____

For what disability? _____

Form #: DC-0005
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I hereby authorize any company, state, teacher or participating local district employer, healthcare provider, and/or government agency to provide to the Maine Public Employees Retirement System any reports or records requested including, without limitation, any medical records, personnel or employment records, and/or insurance benefit records.

A photocopy of this statement will be treated as if an original. I hereby certify that the above statements are true. I understand that the medical records supplied by the caregivers identified above may constitute the sole basis for determining my eligibility to continue to receive disability benefits. MainePERS may, at its discretion and expense, require further medical examination(s) prior to making a final determination.

_____ _____

Signature Date

Note: If this form is being filled out by someone besides the applicant, sign and explain below:

_____

Signature

_____

Your Name (print or type)

_____

Relationship

Explain why you are filling out this form for the applicant: _____

_____

Note: If you are the recipient's Legal Guardian, Appointed Representative or hold a Power of Attorney, please attach a copy of the document giving you this designation.