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) 512-3101
TTY: (207) 512-3102

APPLICATION FOR SURVIVOR RETIREMENT BENEFITS

Beneficiary Of (Deceased Member's Name): Prefix | First | MI | Last | Suffix

Deceased Member's Social Security Number:

Applicant's Name: Prefix | First | MI | Last | Suffix

Social Security Number: Date of Birth:

E-mail:

Mailing Address: Street/PO Box | City | State | ZIP

Daytime Phone #: Alternate Phone #:

What is your current or most recent employment position: _____

Employer: Job Title:

Date you began this job: mm | dd | yyyy

Are you still working?: ❑ Yes ❑No If No, enter date last worked: mm | dd | yyyy

Supervisor Information: Name: _____

Address: _____

Phone #: _____

What illness or injury prevents you from working? (list all conditions that you wish considered)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Have you applied for Workers' Compensation? ❑ Yes (If Yes, attach a copy of the first report of injury) ❑No

Have you received Workers' Compensation benefits? ❑Yes (If Yes, attach a copy of the decision) ❑No

Have you applied for Social Security disability benefits? ❑Yes (If Yes, attach a copy of the receipt) ❑No

Form #: DC-0013
Rev. 3/14

Describe the difficulties that result from the illnesses or injuries you listed on the previous page:

Medical Providers

List the names and addresses of all physicians/hospitals that you have seen or visited for illnesses or injuries you have listed. (Please use an additional sheet of paper for additional providers.)

	Name	Address	Telephone number
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Release of Information

I authorize any company, state, teacher or participating local district employer, healthcare provider, and/or governmental agency to provide to 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. I authorize the release of my home contact information defined as "home address, home telephone number, home fax number and home e-mail address," for the duration of the processing of my disability application, including the period of time needed for any payroll processing and/or any appeal resulting from my application for disability benefits. I may not designate selective release of my home contact information.

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

Signature of Applicant: _____ Date: _____

Note: If this form is completed by someone other than the applicant, please sign and explain below:

Signature: _____ Date: _____

Your Name (print or type): _____

Relationship: _____

Explanation of why you're completing this form for the applicant:

_____

_____

_____

If you believe you have the authority to sign this form on behalf of the applicant, state the basis of your authority. If the basis of your authority is set forth in a document(s), such as a power of attorney or appointment of guardianship, attach copies of all relevant documentation.