Applying for IMRF Disability Benefits

When should you file this form?

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

If you are thinking about resigning, CONTACT IMRF BEFORE YOU RESIGN.

Resigning your position may impact your eligibility for IMRF disability benefits.

Once you have stopped working, use this checklist to help you with the application process:

1. File your *Member's Application for Disability Benefits* (IMRF Form 5.40)

We recommend you complete your application online through your Member Access account at www.imrf.org. You can also mail an application to IMRF or fax it to us at 630-706-4289.

☐ COMPLETED IN MEMBER ACCESS
☐ MAILED
☐ FAXED

_____
DATE YOU SENT YOUR FORM

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2. Ask your employer to file an *Employer's Statement—Disability Claim* (IMRF Form 5.41)

Your employer should complete and submit this form online through Employer Access.

- Write down the name of the person you spoke with and the date.
- Ask when your employer will submit the form to IMRF.

_____
PERSON YOU SPOKE WITH

_____
DATE

_____
DATE EMPLOYER WILL SUBMIT

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3. Give your physician(s) a *Physician's Statement of Disability Claim* (IMRF Form 5.42)**.**

You must give a Form 5.42 to **each** physician who is certifying your disability. Form 5.42 is available online at www.imrf.org. Your physician(s) must send the completed form to IMRF **along with copies of your medical records from the date of your disability**.

- Write down the name(s) of the person you spoke with and the date.
- Ask when the physician(s) will send the form to IMRF.

_____
PERSON(S) YOU GAVE FORM TO

_____
DATE

_____
DATE PHYSICIAN(S) WILL SEND

When IMRF receives any of the above forms, we will mail you an IMRF Disability booklet and request any missing forms.

IMRF
2211 York Road, Suite 500 Oak Brook, IL 60523-2337
Member Services Representatives 1-800-ASK-IMRF (275-4673) Fax: (630) 706-4289
www.imrf.org

Tax information:

Question 14—W-4P Federal Income Tax Withholding

Question 14 on this form serves as a substitute IRS Form W-4P. IMRF disability benefits are subject to federal income tax.

The law requires IMRF to calculate withholding on your monthly disability payments using IRS tax tables unless you give us different instructions.

You can use Question 14 to instruct IMRF to do any of the following:

- Withhold no tax from your disability payments (Question 14a)
- Withhold taxes based on the number of allowances and marital status you indicate (Question 14b)
- Withhold an additional amount you specify from each payment. (Question 14c)

If you leave Question 14 blank, IMRF will withhold the default amount required by the IRS. To view the tax amount to be withheld under current regulations, read "Tax Letter #13," at www.imrf.org under "Forms and Publications Archive/Tax and Topic Letters."

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.

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.

You may use IRS Form W-4P instead of Question 14. Form W-4P is available online at www.irs.gov and at most IRS offices.

Statement of income tax withheld

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.

Tax credit—total and permanent disability

If you are totally and permanently disabled, you may be eligible for a tax credit. For additional information about the tax credit, please contact a tax advisor or call 1-800-TAX-FORM (1-800-829-3676) and request IRS publication 524 "Credit for the Elderly or the Disabled." You can also download IRS publication 524 at www.irs.gov. **IMRF cannot offer tax advice.**

Legal information:

IMRF is authorized to determine continuing eligibility

If you are granted IMRF disability benefits, IMRF is authorized to conduct periodic checks/investigations to determine continuing eligibility. These periodic checks/investigations may result in a determination of ineligibility.

IMRF is not legally authorized to pay a benefit to an ineligible member. **If IMRF finds you ineligible, your benefit will stop the month after this determination.** You will have an opportunity to appeal to the IMRF Benefit Review Committee under IMRF's disability appeal procedures.

By applying for these benefits and signing this form, you indicate you understand your benefits may be terminated if a written report by an IMRF-appointed physician finds that you are no longer disabled, as defined by the Illinois Pension Code.

Additional disability benefit information:

Payment Schedule

IMRF disability payments are paid at the beginning of the month for the previous month. For example, you would be paid on August 1st for July's disability benefits.

Trial work period

If your doctor releases you to return to work on a part-time basis, please review the "Trial Work Period" information in the IMRF disability benefits booklet.

This booklet is available at www.imrf.org. We will also mail you a copy when we receive any of the forms listed on the first page of this form.

How to find your IMRF Member ID

To protect your personal information, IMRF has assigned you a unique seven digit identification number for you to use in place of your Social Security Number on all forms you send to IMRF.

You can find your IMRF Member ID Number in your Member Access account at www.imrf.org. Your Member ID Number is also printed on all correspondence IMRF sends you, including your annual member statement.

MEMBER'S APPLICATION FOR DISABILITY BENEFITS

IMRF Form 5.40 (Rev. 03/2018) ***Please print—use black ink***

Last Name	First	Middle Initial	Jr., Sr., II, etc.	IMRF Member ID or Last 4 Digits of SSN

Street (Mailing) Address	City, State and Zip (zip+4 if known)

Telephone	Cell Phone	Email*

**If you have an IMRF Member Access account, you must update your email through Member Access*

DO NOT COMPLETE THIS FORM IF YOU ARE STILL WORKING

1. Date you last worked:_____ ***Leaving this question blank will delay the processing of your claim***

2. What is your illness or injury?

_____

3. Date of first treatment for this illness or injury (for example the date of your first doctor visit): _____
Leaving this question blank will delay the processing of your claim

4. If claiming disability benefits because of pregnancy:

Expected delivery date:_____

Actual delivery date: _____

5. Did you visit an emergency room or Urgent Care facility? ☐No ☐Yes
If yes, attach a copy of your discharge summary.

6. Was this injury caused by an accident? ☐No ☐Yes
IMPORTANT: If yes, how and where did accident happen?

_____

_____

7. In the past six months have you been off work for the same injury or illness? ☐No ☐Yes

8. Are you applying for workers' compensation and/or occupational disease benefits? ☐No ☐Yes Status:_____

9. Name and address of **ALL** physicians consulted and date of consultation. **Attach an additional sheet if needed.**
You need to give each physician a copy of IMRF Form 5.42 to complete and return. *(See the checklist on the first page of this form for more information)*

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

_____

_____

10. Name and address of **ALL** hospitals where you were treated, including facility from question five. **Attach an additional sheet if needed.**

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

_____

_____

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

_____

_____

_____

12. Do you own your own business? ☐No ☐Yes
If yes, do you work for your business? ☐No ☐Yes
If yes, give name, address and telephone of your business:

_____

_____

_____

13. Do you perform any work or other activities that you are paid for? ☐No ☐Yes If yes, please explain:_____

_____

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

14a. I elect to have no income tax withheld from my disability payments. (Do not complete lines 14b or 14c.)..... ☐

14b. 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 14c.) ..... _____
(number of allowances)

☐Single ☐Married ☐Married, but withheld at higher single rate

14c. I want the following additional amount withheld from each periodic disability payment. .....$_____

Please write your IMRF Member ID or the last four digits of your Social Security Number on all documents you send with this form.

By signing, I certify that this information is correct. I am aware that pursuant to the Illinois Pension Code, 40 ILCS 5/1-135, any person who knowingly makes any false statement or falsifies or permits to be falsified any record in an attempt to defraud IMRF is guilty of a Class 3 felony. If the IMRF Board has a reasonable suspicion that a false record has been filed with the Fund, it is required to report the matter to the appropriate state's attorney for investigation.

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.

Signature **X** _____ Date _____

Completed form may be mailed to: **IMRF** 2211 York Road Suite 500 Oak Brook, IL 60523-2337
Member Services Representatives 1-800-ASK-IMRF (275-4673) Fax: (630) 706-4289