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| {SFNLogo} | **50149-****{stdMbrPERSLinkID}** |
| **APPLICATION FOR RECERTIFICATION OF DISABILITY RETIREMENT BENEFITS** |
| NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM |
| SFN 50149 (Rev. 09-2021)  **{SFNAddress}** |

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| **PART A PARTICIPANT IDENTIFICATION** | | | | | | | | | | | | | | | |
| Name (Last, First, Middle) {stdMbrFullNameLFM} | | | | | | NDPERS Member ID{stdMbrPERSLinkID} | | | | | | | | | | |
| Last Four Digits of Social Security Number {stdMbrLastFourDigitsOfSSN} | | | | | | Date of Birth (mm/dd/yyyy) {stdMbrDateOfBirth} | | | | | | | | | | |
| **PART B STATUS OF OTHER BENEFITS** | | | | | | | | | | | | | | | |
| Are you eligible to receive the following benefits? Please check and complete the appropriate boxes. | | | | | | | | | | | | | | | |
| Yes | No | Benefits | | | Date Benefits Began | | Date Benefits Terminate | | Amount | | Paid Weekly | | Paid Monthly | |
|  |  | Workers Compensation Benefits? | | |  | |  | |  | |  | |  | |
|  |  | Unemployment Compensation Disability? | | |  | |  | |  | |  | |  | |
|  |  | Sick Pay? | | |  | |  | |  | |  | |  | |
|  |  | Social Security Benefits? | | |  | |  | |  | |  | |  | |
|  |  | Retirement Income?(Current or Past Employers) | | |  | |  | |  | |  | |  | |
| **PART C REHABILITATION STATUS** | | | | | | | | | | | | | | | |
| Have you been evaluated for vocational rehabilitation in the last 18 months?NoYes | | | | | Are you presently receiving any type of vocational rehabilitation? No YesIf yes, provide details of the services you are receiving | | | | | | | | | | |
| Name of Vocational Rehabilitation Facility | | | | | | | | | | | | | | | |
| Mailing Address | | | | | | | | City | | | | State | | ZIP Code | |
| **PART D SICKNESS OR INJURY DATA** | | | | | | | | | | | | | | | |
| Date of Sickness or Injury | | | Date You First Noticed Symptoms | | Date You First Saw a Physician For This Sickness or Injury | | | | | | | | | | |
| Cause of Disability | | | | | | | | | | | | | | | |
| Name of Treating Physician (If more than one, list on separate sheet of paper) | | | | | | | | | | | | | | | |
| Address | | | | | | | | City | | | | State | | ZIP Code | |
| If Hospitalized For Sickness or Injury, Give Name of Hospital | | | | | | | | Date Admitted | | | | Date Released | | | |
| Are You Bed Confined?  No  Yes | | | Are You House Confined?  No  Yes | Have You Ever Had The Same Kind of Sickness or Injury Before?  No  Yes. Specify date and physician’s name and address below. | | | | | | | | | | | |
| Date | | | | | | Physician | | | | | |
| Physician’s Address | | | | | | | | | | | |
| Date of Accident? | | | Time of Accident? | Was Accident Work Related?  Yes  No | | | | | | Where Did The Accident Occur? | | | | | |
| Date You Were First Able To Leave Home For Any Purpose? | | | | Date You Were First Able To Do Any Part Of Your Work, Supervisory or Otherwise? | | | | | | | | | | | |

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| Name (Last, First, Middle) {stdMbrFullNameLFM} | | | NDPERS Member ID{stdMbrPERSLinkID} | |
| **PART E STATEMENT OF ANNUAL EARNINGS** | | | | |
| **A. Time Period Certifying (To be completed by NDPERS only)** | | | | |
| Start Date (mm/yyyy) | | End Date (mm/yyyy) | | |
| **B. Employment Verification (To be completed by Member)** | | | | |
| No, I have NOT worked or earned salary for the time period listed in Part E.  Yes, I have worked and earned salary for the time period listed in Part E. My employers name, occupation, and  earnings are as follows: | | | | |
| Employer’s Name | | Occupation | | |
| **Indicate Month(s) and Salary Earned**  **(If Applicable, complete the “Statement of Annual Earnings for Disability Annuitants SFN 53157” for additional time periods)** | | | | |
| Check the Month(s) Worked | Year | | | Indicate Gross Salary Earned |
| January |  | | | $ |
| February |  | | | $ |
| March |  | | | $ |
| April |  | | | $ |
| May |  | | | $ |
| June |  | | | $ |
| July |  | | | $ |
| August |  | | | $ |
| September |  | | | $ |
| October |  | | | $ |
| November |  | | | $ |
| December |  | | | $ |
| January |  | | | $ |
| February |  | | | $ |
| March |  | | | $ |
| April |  | | | $ |
| May |  | | | $ |
| June |  | | | $ |
| July |  | | | $ |
| August |  | | | $ |
| September |  | | | $ |
| October |  | | | $ |
| November |  | | | $ |
| December |  | | | $ |

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| Name (Last, First, Middle) {stdMbrFullNameLFM} | NDPERS Member ID{stdMbrPERSLinkID} |
| **PART F MEMBER AUTHORIZATION** | |
| **Release of Information:**  To all physicians and other medical professionals, hospitals, and other medical-care, institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrators:  You are authorized to provide MidDakota Clinic and any benefit plan administrators, consumer reporting agencies, attorneys, and independent claim administrators acting on MidDakota Clinic’s behalf with information concerning medical care, advice, treatment, or supplies provided the patient, including information relating to mental illness and any employment related information regarding the patient. This information will be used for the purpose of evaluating and administrating claims for benefits.  In understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. If this authorization is given in connection with a claim for disability or life insurance benefits, I understand that it is valid for the duration of the claim.  I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original. | |
| I declare that the foregoing statements are full, true, and correct to the best of my knowledge, belief, and subject to the law and penalties governing any misrepresentation and fraud. | |
| Member’s Signature (Electronic Signature will not be accepted) | Date |