

**EMPLOYER'S STATEMENT
APPLICATION FOR DISABILITY RETIREMENT**

PART I - MEMBER INFORMATION (Who Is Applying for Disability Retirement)

The purpose of this form is to help your employee apply for a disability retirement benefit under the Connecticut Municipal Employee Retirement System (CMERS). All employees who are applying for a disability benefit **are required** to have the employer fill out, complete and enclose this form with his or her disability retirement application.

MEMBER'S NAME (Last)	First Name	M.I.	DATE OF BIRTH	SOC. SEC. NO.
EMPLOYER		CURRENT POSITION/JOB HELD BEFORE INJURY OR ILLNESS		
LAST DATE WORKED		LAST DATE PAID		

PART II - GENERAL INFORMATION

The individual identified above is filing an application for disability retirement from the Connecticut Municipal Employee's Retirement System (CMERS). A member of CMERS is eligible for a disability retirement benefit when he or she becomes permanently and totally disabled from engaging in any gainful employment in the service of the municipality. "Gainful employment" refers to the ability to work at least 20 hours per week on a regular basis and is not limited to the member's own occupation or to comparable employment. To be eligible for a disability retirement, the member must show that he or she is permanently and totally disabled from being able to work at least 20 hours per week on a regular basis in any employment capacity regardless if an employment vacancy exists at the time of application. A member is entitled to disability retirement benefits only when the information submitted with the application shows that he or she meets these requirements.

The "Last Date Worked" is the last date the member actually was physically present at his or her job. This does not include sick or vacation days. The "Last Date Paid" means the last date the member was or will be paid: that is, it is the last day for which the member will receive compensation from his or her employer including sick and vacation days but does not include unpaid leave or leave attributed to worker's compensation.

It is important that you respond to every item listed on the Employer's Statement. If an item is not applicable to the member's application, enter "Not Applicable." Enclose this Employer's Statement with the Applicant's retirement application and send it to the address shown below. You may, if you wish, give it directly to the member for delivery to the appropriate office.

Connecticut Municipal Employees Retirement System
55 Elm Street - 2nd Floor
Hartford, CT 06106
"Medical Disability - Privileged-Private."

PART III - DOCUMENTS REQUIRED FROM EMPLOYER

1. Copies of any and all records regarding the member's physical condition at the time of his or her employment with the employer (*for example*, a pre-employment physical examination or a physical examination taken in connection with a new position).
2. Copies of any and all records regarding the member's physical condition (i.e. medical file) *after* he or she was employed by the employer.
3. Copies of any and all Workers' Compensation reports and/or any Workers Compensation settlement agreements made on behalf of the employee even if the employee is not seeking a service connected disability retirement benefit.

If you need more space in any section, attach a separate sheet and indicate that an attachment is provided.

PART IV - EMPLOYMENT INFORMATION

Has the employee's illness, injury or impairment affected his or her attendance and job performance? Please describe how.

Is the employee currently working in any capacity such as full-time, part-time, "light duty" or modified work? If yes, please explain.

Is the employee's claimed disability the result of or in any way related to a grievance or personnel action? If yes, please explain.

Is the employee currently the subject of a disciplinary investigation? If yes, please note the date the investigation was initiated.

Pursuant to CGS Sec. 7-432, to the best of your (the employer's knowledge, information or belief) was the employee's injury, illness or impairment caused by the intoxication (due to alcohol or drugs) of the employee? If yes, please explain.

Pursuant to CGS Sec. 7-432, to the best of your (the employer's) knowledge, information or belief was the employee's injury, illness or impairment the result of any misconduct on the part of, or by, the employee? If yes, please explain.

If you need more space in any section, attach a separate sheet and indicate that an attachment is provided.

PART V - REASONABLE ACCOMODATION

Did the employee ask for any accommodations to allow him or her to continue to work? Did they ask for any change or adjustment to the job, the work environment or the way work is customarily done to permit them to continue to perform the essential functions of their job? If yes, please explain the nature of the request.

If a request was made, were you (the employer) able to grant the request? Why or why not? (Attach an explanation or any documentation regarding the employee's request for a reasonable accommodation.)

Have you (the employer) offered any modification of job duties or other reasonable accommodation to the employee because of his or her illness, injury or impairment? If so, please explain what was offered the employee and whether it was accepted .

If part time employment was offered the employee as a reasonable accommodation, please explain the position offered, the number of days and hours to be worked and whether it was accepted by the employee.

PART VI - SIGNATURE

I certify that I have read and understand the information contained in this statement, and subscribe, under the penalties of perjury, that the information I have supplied in this statement is true, complete, and correct to the best of my knowledge.

Signature of Employer Representative

Date

Position or Title

Department or Agency

Email Address

Telephone Number

Facsimile Number