Acknowledgment Form - SCD
Municipal Employees Retirement System
CO-1209 Rev 8/2015

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
RETIREMENT SERVICES DIVISION

SERVICE CONNECTED DISABILITY RETIREMENT APPLICATION
APPLICANT ACKNOWLEDGMENT FORM

PART I - GENERAL INFORMATION AND INSTRUCTIONS - PLEASE READ CAREFULLY

The purpose of this form is to help employees applying for a service connected disability (SCD) benefit under the Connecticut Municipal Employee Retirement System (MERS) understand the conditions, requirements and responsibilities with regard to this MERS retirement benefit. All employees who are applying for a service connected disability benefit **are required** to fill out, execute and **return** this form with his or her application.

MEMBER'S NAME (Last)	First Name	M.I.	MEMBER ID	DATE OF BIRTH	SOC. SEC. NO.

EMPLOYER	ADDRESS	PHONE NUMBER

PART II - MEMBER ACKNOWLEDGMENT

I am applying for a service connected disability retirement (SCD) from the MERS. I acknowledge and understand that a MERS service connected disability retirement benefit has certain requirements associated with it as outlined below:

Initial here

_____ I agree to notify MERS immediately should I receive **any** workers compensation benefits (including through a Stipulation or Settlement) after I submit my application or at any time I am receiving a MERS SCD retirement benefit.

_____ I agree to notify MERS immediately should I receive **any** "heart and hypertension benefits" (including through a Stipulation or Settlement) after I submit my application or at any time I am receiving a MERS SCD retirement benefit.

_____ I understand that I must report to MERS the receipt of any social security award or payment while receiving a MERS retirement (SCD) benefit as the receipt of such an award may cause a reduction to my MERS SCD retirement benefit.

_____ I understand that I **cannot** return to work in *any* paid position (including elected positions) for *any* public employer for 20 or more hours a week while receiving a MERS disability retirement benefit without stopping my pension.

_____ I understand that failure to report to MERS such workers compensation payments, heart and hypertension benefits, social security award or a return to work as noted above will result in an overpayment of my MERS benefit and that MERS will recover such overpayment through a reduction to my monthly MERS benefit.

SIGNATURE OF MEMBER : _____ DATE : _____

PART III - WORKERS COMPENSATION PAYMENT INFORMATION CONSENT

I understand that if I am approved for an SCD retirement benefit, and currently receive or in the future receive workers compensation payments, MERS will require my workers compensation payment history, which includes payments made, type of payment, the time period covered by payments as well as a copy of any Stipulation or Settlement entered into pursuant to the Workers Compensation Act in order to calculate my retirement benefit. Signing this form, I hereby authorize and otherwise give consent to:

_____

(Name, Address and Contact Information of Workers Compensation Carrier - Obtain From Employer)

or its representative, agent or employee to give to MERS upon MERS' request ***any and all*** of my workers compensation payment related information as stated above.

SIGNATURE OF MEMBER : _____ DATE : _____

Signature of Witness : _____ DATE : _____