STATE UNIVERSITIES RETIREMENT SYSTEM
1901 Fox Drive
Champaign, Illinois 61820
Telephone 1 (800)275-7877 or (217)378-8800 (C-U Area)
FAX (217)378-9800

APPLICATION FOR DISABILITY BENEFITS THROUGH SURS AND THE PRUDENTIAL INSURANCE COMPANY OF AMERICA, IF APPLICABLE

Instructions: Please read the following instructions carefully for proper completion of the attached Application for Disability Benefits. **Your application must be on file with SURS within one calendar year after the date on which your disability occurred. If this application is not fully completed, it will be returned for completion.**

By law, SURS must have the original copy of the application. If you are using this application to apply for both SURS and Prudential, SURS will forward a copy to their office. The decision on whether you qualify for benefits is made separately between SURS and Prudential; therefore, you could qualify for one benefit and not the other.

Only detach this cover page and the question and answer section in the back. Pages 1 through 10 must be submitted to SURS. Additional physician's statements may be obtained by copying the physician's statement included in this application (pages 8 through 10). Attach any additional physician's statements to the application.

STEP 1 EMPLOYER

1. Fully complete the **Employer Section** (see instruction sheet on back of this page).
2. Forward entire application to the Claimant.

STEP 2 CLAIMANT

1. Fully complete the **Claimant Section**.
2. Schedule an appointment with your attending physician(s) who should review the Employer Section (page 2) concerning job requirements, fully complete the Attending Physician's Initial Statement of Disability, and attach any appropriate documentation. **DOCUMENTATION MUST BE INCLUDED.**
3. Insert Power of Attorney (POA) statement.

To avoid unnecessary delays, be sure all parts of the application are completed according to the instructions.

Employers MUST complete the following on the Application for Disability:

EMPLOYER SECTION – PART 1

1. Name of university, college, or Agency.
2. Full name of the employee applying for disability.
3. Social Security number of the employee.
4. The day the employee became disabled.
5. The last day the employee physically worked.
6. **Last day paid: Last day paid is the date when all sick leave and vacation has been paid out. All sick leave must be exhausted and vacation use is optional.**
7. The beginning and ending dates for the last pay period for which the employee will receive pay.

   (6 & 7 can be estimated, mark estimate box on application if appropriate)
8. Basic monthly earnings is the rate the employee received on his/her last day worked and includes the effective date for this rate. Monthly basis is the number of months worked in a year. This includes percent of time and status of employment by checking the box which applies.
9. Check box that applies, SURS has to know whether or not to forward the application.
10. Check box that applies and if Yes, explain (list the accommodations).
11. Check box that applies and if Yes, include the date they returned to work.
12. Check box that applies and if Yes or disputed, include the information requested.
13. Check box that applies and if Yes, include all the information requested.
14. To be completed in full by the individual responsible for filling out this application.

EMPLOYER SECTION PART II - must be fully completed by the supervisor.

EMPLOYER SECTION - PART 1 (Please print in **BLACK INK**)

1. Name of Employer: _____

2. Name of Employee: _____

3. Social Security Number _____-_____-_____ 4. Date Disability Occurred _____/_____/_____ 5. Last Day worked _____/_____/_____

6. Last day paid: _____/_____/_____ ☐ Actual ☐ Estimated

7. Dates of last payroll period: _____/_____/_____ to _____/_____/_____ ☐Actual ☐Estimated

8. Basic monthly rate of earnings (**as of the last day worked**) $ _____

   Effective date of basic monthly rate of earnings_____/_____/_____

   Monthly basis ☐9 Months ☐12 Months ☐Other _____

   Percent time of position: _____% ☐ Academic ☐ Staff Support ☐ Police/Fire

9. Is claimant enrolled in the Prudential LTD plan? Yes ☐ No ☐

   If yes, what was his/her hire date: _____/_____/_____ Policy #_____

10. Have you and the claimant discussed reasonable accommodations which would allow a return to work or would have allowed him/her to continue working? Yes ☐ No ☐
    Explain:_____

11. If recovered, has claimant returned to work? Yes ☐ No ☐ When? _____/_____/_____

12. Did this disability occur as a result of claimant's employment? Yes ☐ No ☐ Disputed ☐

    If YES or under dispute, please provide policy#, name, address, and phone # of Workers' Compensation administrator:_____
    _____

13. To the best of your knowledge, is the claimant receiving or entitled to receive benefits from any of these sources?

    Workers' Comp? Yes ☐ No ☐ Weekly Benefit $_____ Effective_____/_____/_____

    Employer-Paid Disability Contract? Yes ☐ No ☐ **(Please attach copy of the award letter from the company who administers the plan.)**

    Amount $_____ Per _____ From _____/_____/_____ to _____/_____/_____

    Other? Yes ☐ No ☐ _____

14. **Authorized signature & title of employer representative completing this section:**

_____ _____
(Signature) (Please Print Name)

_____ _____
(Title) (Email)

_____ _____ _____
Phone Fax Date

EMPLOYER SECTION - PART 2 (Please print in **BLACK INK**)
(Physical/Nonphysical aspects of job - To be completed by employee's supervisor)

Employee's Name _____

Occupation: _____

1. In a typical work day, how many hours does claimant spend in each position and can he/she alternate positions?

Position	Total No. of hours	May Alternate Positions: At will	15-30 Minutes	Hourly	Never
Sitting	_____	☐	☐	☐	☐
Standing	_____	☐	☐	☐	☐
Walking	_____	☐	☐	☐	☐
Driving	_____	☐	☐	☐	☐

2. Claimant must

		Never	Occasionally (¼ -2 ½ hours)	Frequently (2 ½ -5 ½ hours)	Continuously (5 ½ -8 hours)
A. Bend/Stoop		☐	☐	☐	☐
B. Climb		☐	☐	☐	☐
C. Reach above shoulder level		☐	☐	☐	☐
D. Kneel		☐	☐	☐	☐
E. Balance		☐	☐	☐	☐
F. Enter data/keystroke		☐	☐	☐	☐
G. Squat		☐	☐	☐	☐
H. Crawl		☐	☐	☐	☐
I. Crouch		☐	☐	☐	☐
J. Lift	Usual_____lbs.	☐	☐	☐	☐
	Max _____lbs.	☐	☐	☐	☐
K. Carry	Usual_____lbs.	☐	☐	☐	☐
	Max _____lbs.	☐	☐	☐	☐
L. Push/Pull	Usual_____lbs.	☐	☐	☐	☐

3. On the job, claimant uses feet for repetitive movements as in operating foot controls.
Right: ☐Yes ☐No Left: ☐Yes ☐No Both: ☐Yes ☐No

4. On the job, claimant uses hands for repetitive action such as:

	Simple Grasping	Firm Grasping	Fine Manipulation
A.Right	☐	☐	☐
B.Left	☐	☐	☐

5. Does job require:
A. Working at heights? ☐Yes ☐No
B. Exposure to marked changes in temperature & humidity or extremes thereof? ☐Yes ☐No
C. Exposure to dust, fumes, gases, chemicals? ☐Yes ☐No

6. Stress/Nonphysical
Stress level of position is: ☐Low ☐Medium ☐High
☐Occasionally ☐Frequently ☐Continuously

7. Vision requirement: ☐Low ☐Normal ☐High

8. Was the employee able to perform the duties of his/her position when they stopped working?
Yes ☐ No ☐ If no, please attach explanation of what problems they were having.

Supervisor's Signature/Title:_____ **Date** _____/_____/_____

EMPLOYEE SECTION - PART 1: PAGES 3, 4, 5,& 6 (Please print in **BLACK INK**)

1. Name:_____ 2. S.S.# _____-_____-_____
3. Address: _____ 4. Birth Date :_____/_____/_____
_____ 5. Home phone(_____)_____-_____
6. Are you enrolled in Prudential ? ☐Yes ☐No 7. Work phone (_____)_____-_____
(supplemental long term disability plan)
8. Sex: ☐M ☐F 9. Marital Status: ☐Single ☐Married ☐Separated ☐Widowed ☐ Divorced
10. Nature of illness and when symptoms first appeared or describe how and where accident occurred: _____/_____/_____ _____
11. Date first unable to work because of disability: _____/_____/_____ 12. Dominant Hand _____
13. My job title is:_____
14. Which of your job duties are you unable to perform? _____
15. What accommodations could be made by your employer to allow you to return to work?
_____
16. Were you disabled during vacation, leave, or layoff? ☐Yes ☐No Date _____/_____/_____
Have you returned to work? ☐Yes☐No Part-time_____/_____/_____ Full-time_____/_____/_____
17. Please provide the names and addresses of the physicians who have been consulted for this condition. Please include dates of consultation. The cost for rendering the reports from your physician(s) is your responsibility.

Name of physician	Address		
_____	_____	___/___/___ First visit	___/___/___ Last visit
Phone # (____)____-_____	_____		
_____	_____	___/___/___ First visit	___/___/___ Last visit
Phone # (____)____-_____	_____		

Important information:

Authorization to release information forms follow on pages 6 & 7 of this application. Both pages 6 and 7 need to be signed and dated allowing SURS and/or Prudential (if applicable) to request medical and psychiatric records pertaining to your disability. Refusal to or revocation of consent to the release of information may result in your claim being denied. If you receive a disability benefit greater than that which should have been paid, SURS/Prudential has the right to recover such overpayments, including the rights to reduce or adjust future benefits, if any.

I, the undersigned, understand that the law governing the State Universities Retirement System provides that disability benefits payable by the System must be reduced by the amount of Workers' Compensation payments received by an employee for any claim, regardless if the cause is different than your current disability claim. In view of this provision, I agree to reimburse the State Universities Retirement System for any overpayment of disability benefits in the event that any compensation is payable to me under any State or Federal Workers' Acts.

_____ _____
(Signature of Employee) (Date)

The original of this page must be mailed to SURS office, a copy or a fax is not acceptable by law as we have to have an original signature. Claim cannot be processed until the original is received.

EMPLOYEE SECTION - PART 2 (Please print in **BLACK INK)**

Section I

I have been a member of:
- ☐ State Universities Retirement System (SURS)
- ☐ State Employees' Retirement System of Illinois (SERS)
- ☐ State Teachers' Retirement System of Illinois (STRS)

Section II

Check if you are receiving or entitled to receive benefits from any of the following sources:

☐ Salary, wages or commissions ☐ Social Security disability ☐ Workers' Compensation
☐ Employer paid disability contract ☐ Other sources

For each source marked, please provide the following information:

Source_____ Amount per month $_____ Effective date___/___/___

Source_____ Amount per month $_____ Effective date___/___/___

Provide documentation of any source indicated above; for example, award notices, denial notices, or applications.

Section III - Bank Authorization

I hereby authorize SURS to direct my recurring payments to my account indicated at the financial institution designated below and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account. This authorization is not an assignment of my right to receive payment. I understand that the financial institution designated reserves the right to cancel this agreement by notice to me. Note: If no financial institution is provided, or your information is incomplete, your check will be sent to your home.

Name of Financial Institution	Phone (include area code) ( ) -
Complete Street Address	
City, State, Zip Code	Routing #
Check **one** box: ☐ Checking Account #_____ ☐ Money Manager Account #_____ ☐ Savings Account #_____	

NOTE: If CHECKING, SAVINGS, or MONEY MANAGER account is marked, tape a voided check or deposit ticket here

Withholding Certificate for Disability Payments

Complete the following applicable lines.

1 Check here if you **do not want any** federal income tax withheld from your disability benefit. (Do not complete lines 2 or 3.) ..... ☐

2 Total number of allowances and marital status you are claiming for withholding from each **periodic** disability payment. (You may also designate an additional dollar amount on line3.)..... ..._____ (Enter number of allowances)

Marital status: ☐Single ☐Married
☐Married, but withhold at higher "single" rate

3 Additional amount, if any, you want withheld from each disability payment. (**Note**: For periodic payments, you cannot enter an amount here without entering the number (including zero) of allowances on line on line 2.) .....$_____

_____ _____/_____/_____
Your signature Date

_____ S.S.#XXX-XX-_____
Print Name

If this withholding form is not completed, SURS will automatically withhold married and three exemptions.

Authorization for Release of information to SURS/Prudential Insurance Company

This authorization is intended to comply with the HIPAA Privacy Rule

I authorize any health plan, physician, heath care professional, hospital, clinic, laboratory, pharmacy, medical facility, employer, worker's compensation carrier, social security, or other health care provider that has provided treatment, payment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any health information concerning me to the State Universities Retirement System (SURS) and the Prudential Insurance Company of America ("Prudential", if applicable) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize any insurance company, employer, the Social Security Administration, or other person or institutions to provide any information, data or records relating to my Social Security, Workers' Compensation, credit, financial earnings, activities or employment history to SURS and Prudential, (if applicable) and its agents, employees, and representatives.

Unless limits*are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose all of my medical records without restriction.

This information is to be disclosed under this Authorization so that SURS and Prudential may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with SURS and Prudential if applicable.

This authorization shall remain in force for the duration of my disability claim. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to SURS at PO Box 2710, Champaign, IL 61825-2710, and if applicable, Prudential at PO Box 13480,Philadelphia, PA 19101. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that SURS/Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release all of my medical records, SURS/Prudential may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to receive a copy of this authorization.

*Limits, if any:_____

_____

X_____ _____/_____/_____
Claimant Signature Date Signed

Social Security Number _____-_____-_____

Both pages 6 & 7 must be signed and returned to our office in order to process your disability claim if a psychiatric diagnosis is given.

Authorization for Release of Psychotherapy Notes to SURS/Prudential Insurance Company

This authorization is intended to comply with the HIPAA Privacy Rule

I authorize any health plan, physician, heath care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment or services to me or on my behalf ("My Providers") to disclose all psychotherapy notes concerning me to the State Universities Retirement System (SURS) and the Prudential Insurance Company of America ("Prudential", if applicable) and its agents, employees, and representatives.

Unless limits*are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose all of my psychotherapy notes without restriction.

This information is to be disclosed under this Authorization so that SURS and Prudential may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with SURS and Prudential if applicable.

This authorization shall remain in force for the duration of my disability claim. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to SURS at PO Box 2710, Champaign, IL 61825-2710, and if applicable, Prudential at PO Box 13480,Philadelphia, PA 19101. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that SURS/Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release all of my psychotherapy notes, SURS/Prudential may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to receive a copy of this authorization.

*Limits, if any:_____

_____

X_____ _____/_____/_____
Claimant Signature Date Signed

Social Security Number _____-_____-_____

Both pages 6 & 7 must be signed and returned to our office in order to process your disability claim if a psychiatric diagnosis is given.

ATTENDING PHYSICIAN'S INITIAL STATEMENT OF DISABILITY
The claimant must pay any costs for the completion of this form and copy of records.

Complete each applicable section of these forms.

Section I - History
1. Name of Claimant:_____ **2.** Social Security # ____-____-____

3. Date of Birth: ____/____/____ **4.** Disability Began ____-____-____

5. Patient's symptoms result from: ☐Illness ☐On-the-job accident ☐Other accident

☐Pregnancy EDD___/___/___ Delivered___/___/___ Type of delivery _____

Date symptoms first appeared:___/___/___ Patient's height:_____ Weight: _____

First visit for this condition:___/___/___ Most recent visit:___/___/___ Dominant Hand ____

Most recent comprehensive exam:___/___/___ Follow-up exam scheduled for: ____/____/____

Frequency of visits: ☐Weekly ☐Monthly ☐Other(specify)_____

Name(s) and address(es) of other treating or referring physician(s): _____

_____

_____

_____

Hospital name:_____ Confinement dates: ___/___/___ to ___/___/___

Section II - Diagnosis
Diagnosis (including any complications): _____

_____

_____

Subjective symptoms: _____

_____

_____

Objective findings (include results of x-rays, all office notes, lab tests, hospital summaries, EKGs, MRIs, scans or mental health records):

_____

_____

_____

(Attach relevant records to support findings - this is required by SURS law)

Section III - Treatment
Describe treatment program, including any surgery, medications, (give dates) physical therapy, or psychotherapy: _____

_____

_____

(SUPPORTING DOCUMENTATION MUST BE ATTACHED TO THE PHYSICIAN STATEMENT OR CLAIM WILL NOT BE ACCEPTED)

ATTENDING PHYSICIAN'S INITIAL STATEMENT OF DISABILITY (Continued)

Section IV - Psychiatric Impairment (complete only if applicable)

- ☐ Class 1 - Able to function under stress and engage in interpersonal relations (no limitations).
- ☐ Class 2 - Able to function in most stress situations and engage in only limited interpersonal relations (slight limitations).
- ☐ Class 3 - Able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).
- ☐ Class 4 - Unable to engage in stress situations or engage in interpersonal relations (marked limitations).
- ☐ Class 5 - Significant loss of physiological, personal, and social adjustment (severe limitations).
- ☐ Remarks: _____

What stress and problems in interpersonal relations has claimant had on the job? _____

Do you believe a legal guardian should be appointed for this claimant? ☐**Yes** ☐**No**

Section V - Physical Impairment *As defined in the Federal Dictionary of Occupational Titles

- ☐ Class 1 - No limitation; capable of heavy work.
  Exert 50-100# force occasionally and/or 25-50# force frequently.
- ☐ Class 2 - Medium activity; capable of medium work.
  Exert 20-50# force occasionally and/or 10-25# force frequently.
- ☐ Class 3 - Slight limitation; capable of light work.
  Exert up to 20# force occasionally and/or up to 10# force frequently.
- ☐ Class 4 - Moderate limitation; capable of sedentary, clerical or administrative work.
  Exert up to 10# force occasionally, mostly sitting.
- ☐ Class 5 - Severe limitation; incapable of minimal activity or sedentary work.
- ☐ Remarks: _____

Section VI - Cardiac

Functional capacity (American Heart Association). Complete only if applicable.

☐ Class I (No limitation) ☐ Class II (Slight limitation)

☐ Class III (Marked limitation) ☐ Class IV (Complete limitation)

(SUPPORTING DOCUMENTATION MUST BE ATTACHED TO THE PHYSICIAN STATEMENT OR CLAIM WILL NOT BE ACCEPTED)

ATTENDING PHYSICIAN'S INITIAL STATEMENT OF DISABILITY (Continued)

Section VII - Work Capabilities

Doctor: Check if you have reviewed the: ☐ Job Description (see Employer Section Part II)

Fully describe how claimant's symptoms/limitations affect ability to work, e.g., how work schedule/duties are restricted and why? _____

_____

_____

_____

Section VIII - Prognosis

Prognosis (check one): ☐ Terminal ☐ Poor ☐ Good ☐ Excellent

Would any further therapy be reasonably expected to result in full or partial recovery?

☐ Yes(describe below) When____/____/____ ☐No ☐Unknown

_____

_____

Has claimant reached maximum medical improvement?

☐ **Yes** ☐ **No** If "No" When____/____/____ ☐ Unknown

Is claimant released to return to duty? ☐ **Yes** ☐ **No**

If released, what date did you release them?____/____/____ ☐ Restrictions (list) _____

_____

_____

Are restrictions permanent? ☐ **Yes** ☐ **No** If no, how long _____

Section IX - Rehabilitation

Is claimant a candidate for rehabilitation services? ☐**Yes** (describe) ☐ **No** (explain)

_____

Would job modification enable claimant to work with impairment? ☐**Yes** (describe)☐**No**(explain)

_____

Section X - Physician Information

_____ _____

(Physician's Signature) **(Please Print Physician's Name Here)**

_____ _____

(Street Address) **(Degree/Specialty)**

_____ _____

(City, State, Zip Code) **(License Number)**

_____ _____

(Telephone) **(Fax)**

_____

(Date Completed) – Required!

(SUPPORTING DOCUMENTATION MUST BE ATTACHED TO THE PHYSICIAN STATEMENT OR CLAIM WILL NOT BE ACCEPTED)

STATE UNIVERSITIES RETIREMENT SYSTEM
1901 Fox Drive
Champaign, IL 61820
Phone Number 800-275-7877

DISABILITY BENEFITS

Answers to your questions

WHO IS ELIGIBLE? You may claim disability benefits after you have at least two years of service credit and you become unable to perform your job due to illness. There is no minimum service credit required to claim disability benefits if you become disabled due to an accident.

HOW CAN I APPLY? You should request an Application for Disability Benefits from the Personnel or Benefits Office on your campus. The application should be submitted to the State Universities Retirement System (SURS) after you and your employer have completed the sections of the application that apply to each of you respectively, and your physician has completed his or her portion and has attached appropriate medical documents.

WHEN SHOULD I APPLY? You should complete the application IMMEDIATELY if your disability is expected to last more than 60 days. If you are unsure of whether your disability will last 60 days or longer, you should still complete an application. Your application must be on file with SURS within one calendar year after the date on which your disability occurred.

AFTER I SUBMIT MY APPLICATION, WHAT HAPPENS? Once a completed application is received at the SURS office, the Medical Claims Processor then recommends whether you will be eligible for benefits based upon the medical information received. After review of your claim, the Medical Claims Processor will notify you in writing.

IS THERE ANYTHING ELSE I NEED TO DO AFTER I SUBMIT MY APPLICATION? You could be asked by SURS Medial Claim Processor to have an additional examination done by another physician.

WHO PAYS FOR THE EXAMINATION IF I AM ASSIGNED TO SEE ANOTHER PHYSICIAN? SURS is responsible for payment when the Medical Claims Processor assigns you to see another physician. You will not be asked for payment for this exam.

WHEN ARE DISABILITY BENEFITS PAID? Benefits are paid on the last day of the month for the current month. Benefits due for January are paid on January 31st.

WHEN WILL MY BENEFITS BEGIN? There is a 60-day waiting period before you are eligible to receive your SURS disability benefit. If at the end of your 60-day waiting period, you have been paid all your accumulated sick leave and you are still disabled, your benefit will begin to accrue on the 61st day of your disability. For example:

Last day worked:	May 31, 2008
60-day waiting period:	June 1 – July 30, 2008
Date your benefits begin:	July 31, 2008

WHAT IF I HAVE A LOT OF SICK LEAVE AND MY EMPLOYER CONTINUES TO PAY MY SICK LEAVE LONGER THAN THE 60-DAY WAITING PERIOD? By law, you must exhaust all accumulated sick leave before your SURS disability can begin. Therefore, if your sick leave lasts longer than 60 days, your disability benefit will begin to accrue immediately following your last day of paid sick leave, assuming you remain disabled. Law does not require you to exhaust your vacation before benefits can begin; however, please check with your benefits office regarding their policies. Example:

Last day worked:	May 31, 2008
60-day waiting period:	June 1 – July 30, 2008
Sick leave through:	August 15, 2008
Date your benefits begin:	August 16, 2008

AFTER THE 60 DAYS EXPIRE, WILL SURS PAY BENEFITS BACK TO THE LAST DAY I WORKED? The laws governing your retirement system do not allow any payment of benefits for the first 60 days. Therefore, your payment will not be retroactive to your last day of work.

HOW MUCH WILL I RECEIVE EACH MONTH WHILE I AM DISABLED? You will receive either 50% of the monthly salary you were receiving at the time you became disabled or 50% of your average earnings for the 24 months prior to the date you became disabled, whichever is greater.

WHO SHOULD I CONTACT IF I HAVE QUESTIONS WHILE MY APPLICATION FOR BENEFITS IS BEING PROCESSED? You may contact a SURS Benefits Counselor at 1-800-275-7877 or in 217-378-8800 in the Champaign-Urbana area. Faxes can be sent to 217-378-9800.