

# LONG-TERM DISABILITY BENEFIT CLAIM INSTRUCTIONS

## GENERAL INFORMATION

**WHEN TO APPLY** - You may not apply before the last day you worked. Your benefit, if approved, will usually be effective the day after your last day paid.

The Wisconsin Administrative Code requires that we provide a copy of your completed claim form to your employer. Your employer will be required to submit an Employer Certification based on the described medical condition listed on your claim form.

**SECTION 1 - CLAIMANT INFORMATION** - Type or print in ink. Complete this entire section.

Social Security numbers are required to maintain members' accounts and for federal tax purposes. Statutory authority is contained in Wis. Stat. § 40.03 and section 6109 of the Internal Revenue Code.

**OCCUPATION** - Enter your occupation at the time you became disabled.

**COUNTY OF RESIDENCE** - Enter county in which you live.

**DATE LAST RENDERED SERVICES** - Enter your last day worked. This is the last day on which you were physically present at your employment (Wisconsin Retirement System covered employment).

**EMPLOYMENT AFTER LAST RENDERED SERVICES** - Indicate whether you have had any employment since service for the participating employer ceased. This includes self-employment or employment with any other employer where you received earnings, wages, salary or other earned income in any month since you last rendered services to the participating employer.

**LAST DAY FOR WHICH EARNINGS WERE PAID** - Enter the last date for which earnings were or will be paid from your employer. Any earnings to which you may be entitled beyond your last day worked, such as vacation, compensatory time, sick leave, etc., would extend this date. For example, if your last day work was September 30 and you received two weeks of vacation pay, your "last day for which earnings were paid" is October 14.

**EFFECTIVE DATE OF BENEFIT** - Your benefit effective date is normally the day after your last day for which earnings were or will be paid; however, it can be no earlier than 90 days before we received your claim. Benefits that are not effective on the day after your last day paid must always be effective on the first of a month. Therefore, your benefit will be effective on either the day after your last day for which paid or the first of the month after backdating 90 days, whichever is later.

**COVERED UNDER SOCIAL SECURITY** - Indicate whether you have paid into Social Security during your work history and may be eligible for a Social Security benefit upon reaching the appropriate age. If you will be eligible for a Social Security benefit in the future, your long-term disability insurance benefit amount is based on 40% of your final average salary. If you are not eligible for a Social Security benefit in the future (some protective and teaching employees), your long-term disability insurance benefit is based on 50% of your final average salary. You are required to sign an authorization to release information from the Social Security Administration to verify any Social Security coverage.

**APPLICATION FOR OTHER BENEFITS** - Indicate whether you have applied or are eligible for a Wisconsin Retirement System (WRS) annuity or separation. If you have applied or are eligible to apply for a WRS annuity, your long term disability benefit will be reduced by the taxable portion of the WRS annuity.

**OVER**

If you have applied for a WRS separation benefit, your long-term disability benefit will be suspended until the equivalent of the taxable portion of the lump sum payment is recovered.

If you are receiving temporary disability benefits from Worker's Compensation, your employer must report earnings and service to the retirement system as if you were working. These earnings will extend your "last day for which earnings were paid."

**SECTION 2 - MEDICAL INFORMATION** - Briefly describe your medical condition (physical or mental) which required you to cease working. Indicate the name and address of your current attending physician and any other physicians involved with treating your disabling condition. Indicate the other physicians' specialty (orthopedic, internal medicine, oncology, etc.). The physicians must be licensed and practicing medical doctors.

### **SECTION 3 - FINANCIAL INFORMATION**

#### **INCOME TAX WITHHOLDING ELECTION**

Indicate if you want federal and Wisconsin income taxes withheld by checking "Yes" or "No." If "Yes," indicate a filing status and the number of exemptions or enter a specific amount to be withheld. If you do not complete the election for federal taxes, we are required to withhold federal income taxes based on 20% of the taxable amount of the benefit. Wisconsin does not require state income taxes to be withheld from your benefit. Your long-term disability benefit is fully taxable.

**SECTION 4 - CLAIM CERTIFICATION** - Sign your claim form. By applying for the long-term disability benefit, you are waiving your rights to any benefit under current Chapter 40 and Chapters 40, 41 or 42, Laws of 1979, Wis. Stats. Before signing your claim form, make sure that you clearly understand what benefit rights you are waiving.

## LONG-TERM DISABILITY BENEFIT CLAIM FORM

Wis. Admin. Code § ETF 50

**SEE COVER FOR INSTRUCTIONS**

**TYPE OR PRINT IN INK**

1. Claimant's Name (Last, First, Middle, Maiden)		Social Security Number	
Date of Birth (MM/DD/CCYY)	Employer	Occupation (Title)	County of Residence
Date Last Rendered Services (MM/DD/CCYY)	Have you had any employment after the last rendered services date? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last day for which earnings were paid	Effective Date (ETF Use Only)
Covered Under Social Security? (SEE INSTRUCTIONS)  <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you applied for any of the following benefits:		
		<u>Yes</u>	<u>No</u>
		<u>Eligible</u>	
	Wisconsin Retirement System Annuity	<input type="checkbox"/>	<input type="checkbox"/>
	Wisconsin Retirement System Separation	<input type="checkbox"/>	<input type="checkbox"/>
	Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>

**2. Medical Information** Briefly describe the medical condition (physical or mental) which required you to cease working. Please list all conditions.

Name of Attending Physician	Address (Street, City, State)	Specialty	Date of Last Visit
Names of Other Physicians Involved With Your Treatment	Address (Street, City, State)	Specialty	Date of Last Visit (MM/DD/CCYY)

**3. Financial Information**

<p>1. Do you want FEDERAL taxes withheld? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes and you want withholding based on the tax tables, indicate filing status and number of exemptions:</p> <p style="text-align: center;"><input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED</p> <p>Number of exemptions _____. Or, if you want a specific amount withheld each month, enter amount: \$_____.</p>	<p>2. Do you want WISCONSIN taxes withheld? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes and you want withholding based on the tax tables, indicate filing status and number of exemptions:</p> <p style="text-align: center;"><input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED</p> <p>Number of exemptions _____. Or, if you want a specific amount withheld each month, enter amount: \$_____.</p>
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**4. Claim Certification**

I understand that Wis. Stat. § 943.395 provide criminal penalties for knowingly making false or fraudulent claims, and hereby certify, to the best of my knowledge and belief, the above information is true and correct. By applying for this benefit, I hereby waive my rights to any disability benefits under the current Chapter 40 (except Wis. Stat. § 40.65), and Chapters 40, 41 or 42, Laws of 1979.

Signature of Claimant	Date Signed (MM/DD/CCYY)	Telephone Number (      )
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Claimant's Address (Street, P. O. Box, City, State and Zip Code)

Return form to: Department of Employee Trust Funds P.O. Box 7931 Madison WI 53707-7931	Employer Number _____	Effective Date _____ Final Average Salary _____ Date Benefits Terminate _____ Initial Benefit Amount _____
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