

State of New Jersey — Department of the Treasury
Division of Pensions and Benefits • PO Box 297 • Trenton, New Jersey 08625-0297 • (609) 292-7524

EMPLOYER CERTIFICATION FOR DISABILITY RETIREMENT

1. Retirement System (Check appropriate fund) [] PERS [] TPAF [] PFRS [] SPRS [] JRS

2. NAME OF EMPLOYEE NAME OF EMPLOYER
TITLE / POSITION (at time of retirement) (Attach job description - PERS only) EMPLOYER'S ADDRESS
SOCIAL SECURITY NUMBER EMPLOYER'S ADDRESS (Continued)
MEMBERSHIP NUMBER EMPLOYER'S PHONE NUMBER

3. Date employee's service terminated (Applicant will not render any service to or earn salaries, wages, fees or other compensation from this agency after this date.)

4. EMPLOYEE STATUS [] Full-Time [] Part-Time
Is there an alternate job/position available to the member? [] NO [] YES

5. AUTHORIZED LEAVE OF ABSENCE
[] Paid Sick Leave - Dates from to
[] Paid Personal Leave - Dates from to
[] Unpaid Sick Leave - Dates from to
[] Unpaid Personal Leave - Dates from to
[] Temporary Disability Insurance - Dates from to

6. UNAUTHORIZED LEAVE OF ABSENCE — Dates from to

7. a) Is the member currently on suspension? [] NO [] YES If yes, give date of suspension
Is suspension [] PAID or [] UNPAID

b) Is the applicant facing disciplinary action? [] NO [] YES If yes, attach copies of the preliminary and final notices of disciplinary action or their equivalents, or any settlement agreement in lieu of disciplinary action.

c) Is the applicant facing indictment? [] NO [] YES If yes, attach a copy of the indictment.

8. Was applicant dismissed? [] NO [] YES If yes, give reason and date

TYPE OF DISABILITY RETIREMENT (Select One) — [] ORDINARY [] ACCIDENTAL (Give dates of accident(s) below)

1) 2) 3) 4)

Is this an Involuntary Disability Retirement? [] NO [] YES

If yes, please provide a written statement of grounds for requesting an involuntary retirement.

[]

9. Is there any other job/position available to member? [] NO [] YES If yes, attach a description of the available job/position

10. IF THE EMPLOYEE IS FILING FOR AN ACCIDENTAL DISABILITY RETIREMENT, PLEASE COMPLETE THE SECTION BELOW

a) Did this accident occur during the performance of the employee's duties? [] NO [] YES

b) Is a record of this accident on file? [] NO [] YES If yes, attach copy of accident report, including any witness statements.

c) Was this accident a result of the employee's negligence? [] NO [] YES

d) Has the employee filed a claim for Workers' Compensation? [] NO [] YES

If yes, dates of periodic payments from to

NAME OF WORKERS' COMPENSATION CARRIER

ADDRESS CLAIM NUMBER

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11. Base salary subject to pension fund contributions paid for the last full year of service ending on the date of termination (line 3 above); please list number of months at a particular salary and show a total of 12 months for a 12-month employee or 10 months for a 10-month employee.

TOTAL

_____ months @ \$ _____ from _____ to _____ \$ _____

_____ months @ \$ _____ from _____ to _____ \$ _____

_____ months @ \$ _____ from _____ to _____ \$ _____

_____ months @ \$ _____ from _____ to _____ \$ _____

TOTAL BASE SALARY PAID FOR LAST YEAR OF SERVICE \$ _____

12. Has member received a significant annual salary increase in the last 3 years of employment? NO YES *If yes, please provide a detailed explanation with documentation such as salary guides and employment contracts and ruling body minutes.*

13. Has there been any retroactive salary paid to the employee within the past three years? NO YES *If yes, please describe below:*

AMOUNT OF PAYMENT	DATE OF PAYMENT	COVERING THE DATES (FROM - TO)	PENSION DEDUCTION	NEW ANNUAL BASE
\$		TO	\$	\$
\$		TO	\$	\$
\$		TO	\$	\$

14. The following deductions have been made or will be made from the member's base salary during the final two quarterly periods including the quarter in which service terminated (see QUARTERLY REPORT OF CONTRIBUTIONS).

State biweekly reporting agencies should attach a screen print of TREADHOC biweekly certification with salaries projected until termination date in lieu of Item 13.

QUARTER ENDING	BASE SALARY SUBJECT TO CONTRIBUTIONS THIS QUARTER	PENSION CONTRIBUTION	LOAN REPAYMENT	BACK DEDUCTIONS		ARREARS AND/OR PURCHASES	TOTAL PENSION DEDUCTIONS
				NO. PAYMENTS	AMOUNT		
	\$	\$	\$		\$	\$	\$
	\$	\$	\$		\$	\$	\$

✓ CHECKLIST — The following items must accompany this form:

- _____ 1. **Current Job Description (If question #9 is answered YES, include description of any other available jobs.)**
- _____ 2. **Copies of indictments, convictions, and/or preliminary and final notices of disciplinary action. (If Question #7 is answered yes.)**
- _____ 3. **Copies of accident reports, incident reports, witness statements, medical records relating to the incident, and other related documents.**
- _____ 4. **Copies of Workers' Compensation awards.**

Name of Certifying Officer _____ Phone Number (____) _____

By signing this statement I am certifying, under penalty of perjury, to the truthfulness of the information contained herein.

Certifying Officer Signature _____ Date _____

NOTE: If a member of the retirement system qualifies for periodic benefits payable under the Workers' Compensation law during the course of active employment, regular pension contributions must be paid to the system by the employer. The payments are computed on the base salary paid immediately prior to the receipt of Workers' Compensation benefits. These payments are credited to the member's account in the system and will be treated as employee contributions for all benefit or claim purposes.

