North Carolina Total Retirement Plans

Reporting Earnings Benefits and Medical Report for Eligibility Review

Please print or type in black ink.

Section A. Tell us about yourself.

FIRST NAME	MI	LAST NAME	SUFFIX	SSN (Last 4 digits)
MAILING ADDRESS				MEMBER ID
CITY	STATE	ZIP CODE	TELEPHONE NO.	DATE OF BIRTH
POSITION TITLE				TODAY'S DATE

Section B. Please submit this form on the 1st day of each calendar month.

During the waiting period, and during the short-term while you are receiving short-term disability benefits, you must report any earnings to you employer. The report (this form) is due on the 1st of every calendar month, and it should state earnings **received** during the previous calendar month. This form is required because the amount of your benefit may be affected by the amount of your earnings.

- The earnings you must report on this form include all compensation for work performed by you, including salaries, wages, fees, commissions, and net profits from self-employment.
- You should **not** report public assistance, child support, rental income, or income from investments.
- You do not need to report your short-term benefit or any private disability insurance.
- You do not need to report income from your System employer that administers your short-term benefit. It is your employer's responsibility to report that income and add it to any income you report to make benefit calculations
- If you are working for a second System employer that is not administering your benefit, you need to report that income.

You must submit this form to your employer even if you had no earnings. After your employer has received the first page of this form from you, your employer will complete the second page of the form and authorize payment from the payroll if a benefit is due.

Section C. Please tell us about any earnings during the past month.

1 This form represents a report of earnings **received** during the month of (MM-YYYY): ____ / ____ **1**

2 Did you receive any compensation during this month? ☐ YES ☐ NO **2**

If **YES**, please give information about your earnings below. Attach copies of pay stubs or earning statements signed by your employer.

Source of Income or Employer	Gross Amount Received	Date Received

I certify that all answers are true and correct to the best of my knowledge, and I understand that any misstatement is unlawful and may disqualify me from receiving benefits under the Disability Income Plan of North Carolina.

Signature _____ Date _____

Section D. Please authorize to release your medical reports.

I hereby authorize the undersigned medical professional to release any information acquired in the course of my examination or treatment to my employer as indicated below or to the Retirement System Division. I understand that this information is to be furnished at no cost to my employer or to the Retirement Systems Division.

Signature of Patient/Applicant _____ **Today's Date** _____

Applicant: *Please give this form to a certified medical professional (physician, physician's assistant, family nurse practitioner, psychiatrist, psychologist, or chiropractor) to complete at the time of disability and every 30 days thereafter.*

Please continue to the next page.

N.C. Department of State Treasurer, Retirement Systems Division
3200 Atlantic Avenue, Raleigh, North Carolina 27604
1-877-NCSECURE (1-877-627-3287) toll-free
www.myncretirement.com

REV 20100121

702

Section E. Medical Professional, please tell us about your practice.

NAME OF MEDICAL PROFESSIONAL'S PRACTICE				
FIRST NAME	MI	LAST NAME	TITLE	LICENSE NO.
MAILING ADDRESS				**DO NOT SEND A BILL TO THE RETIREMENT SYSTEM**
CITY	STATE	ZIP CODE	TELEPHONE NO.	

The Retirement System **will not** assume any responsibility for payment of fees for furnishing the requested information.

Section F. FOR MEDICAL PROFESSIONAL USE ONLY: Describe the disabling illness.

***Medical Professional**: As the patient's advocate, please describe the patient's illness(es) or condition(s) that may qualify the applicant for disability benefits and substantiate this information so that the patient's eligibility for benefits can be determined.*

1 **What** is the principle cause of the disability? 1

2 **How** does this illness(es) specifically prevent the applicant from performing his/her usual occupation? 2

3 Please indicate the diagnosis(es) and whether each is causing or contributing the disability. 3

Diagnosis (Full Name **Required**)	Causing or Contributing?	Code (Optional)

4 What date did the patient become unable to work, that is, disabled (mm-dd-yyyy)? ___ / ___ / ___ 4

5 What is the expected duration of the members disability? 5

Section G. Medical Professional, please certify your evaluation for the member's visit.

I hereby certify that the patient named in Section A of this form became disabled to perform his/her regular job on the day given (Question 4) with the diagnosis(es) (Question 3), and that he/she was continuously disabled to the extent that he/she could not perform his/her regular job through today's evaluation date below or the last day of the illness, whichever is first.

Date of Office Visit	**Physician's Signature** (Stamps are not accepted)	**Date of Signature**

Section H. Employer Information

Please submit this form (form 702) to the employer listed in this section (Section H).

EMPLOYER CONTACT FIRST NAME	EMPLOYER CONTACT LAST NAME	EMPLOYER CONTACT JOB TITLE	
EMPLOYER			TELEPHONE NO.
MAILING ADDRESS			FAX NO.
CITY	STATE	ZIP CODE	E-MAIL ADDRESS

Submit this form to your employer to receive short-term benefits.

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MEMBER LAST NAME	MEMBER SSN (Last 4 digits)