



Employees' Retirement System of Rhode Island

ANNUAL CONTINUING STATEMENT For Members Receiving a Disability Retirement Allowance

This *Continuing Statement* must be completed and submitted to the person referenced below on or before **May 5, 2017** except for the *Medical Update* which may be submitted at any time during the calendar year. For additional information, please refer to the *Frequently Asked Questions* sheet or call or email the person referenced below.

Send completed forms to:

Employees' Retirement System of Rhode Island
Re: Disability Compliance
50 Service Avenue, Second Floor
Warwick, RI 02886-1021

Fax: 401.462.7691
Phone: 401.462.7649

❖ **SECTION A: MEMBER GENERAL INFORMATION**

Name:	Email Address:
Mailing Address:	Public employer at time of retirement:
	Public job position at time of retirement:

❖ **SECTION B: REQUIRED DOCUMENTATION (Due by May 5, 2017)**

1. Please attach a copy of your **2016** Federal Tax Return *Form 1040*. (You must attach a copy even if you were not employed.) If you will not be filing a Federal Tax Return, please check the appropriate box below.

2. Please include copies of all corresponding wage attachments (W-2s, 1099's, etc.) and business income attachments (Schedule C's, K-1s, S-Corp Form 1120, Partnership Form 1065, etc.). If filing jointly, you must include the attachments and schedules for both you and your spouse.

- My **2016** Federal Tax Return is attached.
- I was granted an extension to file my **2016** Federal Tax Return by the IRS. I will provide a copy upon filing. My extended due date is: _____.
- I certify that I am not filing a **2016** Federal Tax Return.

❖ SECTION C: EMPLOYMENT INFORMATION (Due by May 5, 2017)

1. Were you employed (includes self-employment) during **2016**? Yes No

If Yes, please complete the table below:

Employer Name & Location	Job Position Held	<u>2016</u> Amount Earned (use <u>gross</u> wages and <u>net</u> business income)
		\$
		\$
		\$
Total Amount of Earned Income for <u>2016</u>		\$

2. Did you receive any workers' compensation benefits during **2016**? Yes No

If Yes, please provide the amount: \$ _____

3. Did you receive any unemployment benefits during **2016**? Yes No

If Yes, please provide the amount: \$ _____

❖ SECTION D: ANNUAL CERTIFICATION (Due by May 5, 2017)

I, the undersigned, certify under penalty of law that, to the best of my knowledge, all the information that I have provided in this *Annual Continuing Statement* is accurate and truthful. Furthermore, I certify that I remain unable to be gainfully employed in the position that I held at the time of my retirement because of a disability.

Member's Signature: _____ Date: _____

Member's Name (please print): _____

Notarization: State of _____ County of _____.

On this ____ day of _____, 20____, before me, the undersigned notary public, personally appeared the above named member personally known to the notary or proved to the notary through satisfactory evidence of identification to be the person whose name is signed above, and acknowledged to the notary that he or she signed it voluntarily for its stated purpose.

My Commission Expires: _____ Notary ID Number: _____

Notary Public Signature: _____



Employees' Retirement System of Rhode Island

ANNUAL MEDICAL UPDATE

For Members Receiving a Disability Retirement Allowance

Please take this page with you to one of your doctor's appointments during 2017.

Name of Member:	Member Date of Birth:
Doctor's Name:	Date of Examination:

To be completed by your Doctor **(Due by December 29, 2017)**

Please provide a response to the following statement based on your medical opinion.

The Member likely remains unable to work in the position from which he or she retired.	
Yes <input type="radio"/>	Further independent examination is recommended to determine. <input type="radio"/>

Please attach a copy of the Member's current medical report.

Additional Notes (Optional):

Doctor's Signature: _____ Date: _____

This box is only applicable for Members who are unable to see a doctor during 2017. Member, please check the reason below and return to ERSRI.		
I cannot afford to see a doctor. <input type="radio"/>	I do not have a doctor. <input type="radio"/>	My doctor will not sign the form. <input type="radio"/>
Other (please explain): _____		

Please submit this form to:

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