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FORM 1 (Recipient to Complete)

REPORT OF CONTINUING DISABILITY

Recipient Name:

Prefix	First	MI	Last	Suffix

Mailing Address:

PO Box/Street Address	City	State	ZIP

Last Four Digits of Social Security Number: Daytime Telephone #:

1. List the condition(s) for which you were granted MainePERS disability benefits: _____

2. What symptoms are you currently experiencing? _____

3. What are you unable to do as a result of these symptoms? _____

4. List the name, address and telephone number for providers who have treated you for this condition(s) in the last 12 - 18 months:

1.	_____	_____	_____
	Name	Address	Telephone Number
2.	_____	_____	_____
	Name	Address	Telephone Number
3.	_____	_____	_____
	Name	Address	Telephone Number
4.	_____	_____	_____
	Name	Address	Telephone Number

5. Have you engaged in any work activity since your retirement?: Yes No

If "Yes": number of hours worked per week _____
 amount of hourly pay \$ _____
 dates of employment _____

What are/were your duties? _____

Place of Employment: _____

If no longer working, when and why did you leave? _____

6. Are you receiving any of the following?:

Workers' Compensation: Yes No Social Security Disability Benefits: Yes No

If "Yes," to either of the above, amount received monthly \$ _____

For what disability? _____

I hereby authorize any company, state, teacher or participating local district employer, healthcare provider, and/or government agency to provide to the Maine Public Employees Retirement System any reports or records requested including, without limitation, any medical records, personnel or employment records, and/or insurance benefit records.

A photocopy of this statement will be treated as if an original. I hereby certify that the above statements are true. I understand that the medical records supplied by the caregivers identified above may constitute the sole basis for determining my eligibility to continue to receive disability benefits. MainePERS may, at its discretion and expense, require further medical examination(s) prior to making a final determination.

Signature

Date

Note: If this form is being filled out by someone besides the applicant, sign and explain below:

Signature

Your Name (print or type)

Relationship

Explain why you are filling out this form for the applicant: _____

Note: If you are the recipient's Legal Guardian, Appointed Representative or hold a Power of Attorney, please attach a copy of the document giving you this designation.