ERS EF-ANN DIS
06/13

QUESTIONNAIRE ON DISABILITY RETIREMENT

Employees' Retirement System of Alabama
P. O. Box 302150 ♦ Montgomery, AL 36130-2150
334-517-7000 or 877-517-0020
www.rsa-al.gov

Name _____
First Middle Last

Social Security No. _____ Telephone _____

Name(s) of Physician(s) _____

_____

_____

After retirement, were you employed last year? ☐ Yes ☐ No

If employed, please complete the following:

Name of Employer _____

Address of Employer _____
Street City State Zip Code

If employed, when did you work? FROM _____ TO _____
Month Day Year Month Day Year

What has been your income from the above employment for the calendar year January 1, 20____ to December 31, 20___?

(Include salaries, bonuses, commission, etc.) $_____

Any person who makes a false statement or falsifies a record in any attempt to defraud the Retirement System shall be guilty of a misdemeanor, and upon conviction, be punished by a fine up to $500.00 and/or imprisonment not to exceed one year.

I hereby certify that the above answers are true and correct. I request and authorize my physician and my employer to furnish the Retirement System with any desired information to be used in connection with my retirement disability. I further authorize the release of any pertinent information from any source available to the Retirement System to verify the status of my employment and the earnings thereof.

Signature of Retiree _____

Sworn to and subscribed before me this _____ day of _____, 20 _____.

Signature of Notary Public _____

Seal My Commission Expires _____