



46 State House Station
 Augusta, ME 04333-0046
 Telephone: (207) 512-3100
 Toll-free: 1-800-451-9800
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APPLICATION FOR SURVIVOR BENEFITS

Please **print** or **type** all answers. If you need more space, use separate sheets of paper and clearly identify each question by number. The information requested on this form will be used to document your claim for a survivor benefit. Your disclosure of this information is voluntary, but failure to provide all or part of the requested information may affect the determination of your claim. Your medical records will be kept confidential with the exception that they may (1) be obtained by your employer for any purposes relating to any claim for Workers' Compensation or any other benefit and/or (2) be subject to disclosure when involved in proceedings resulting from an appeal of any decision we make on your claim. If your employer makes a request to obtain your medical records, the MainePERS must notify you in writing that such a request has been made.

BENEFICIARY OF (DECEASED MEMBER'S NAME): _____

DECEASED SOCIAL SECURITY #: _____

Applicant Name:	(Last)	(First)	(Middle)
Home Address:	(Street)	(City/Town)	(State) (Zip)
Daytime Telephone Number:	Date of Birth:	Social Security Number:	

A. ABOUT YOUR CONDITION(S)

Please list the condition(s) which relate to your claim for a change in the normal beginning/ending date of your survivor benefits, and indicate the date of onset of each condition. Please include all conditions you want considered. You will also need to complete an Addendum page (included with this application) for each condition.

Condition: _____ Date: _____

Condition: _____ Date: _____

Condition: _____ Date: _____

B. ABOUT YOUR MEDICAL RECORDS

1. Furnish the following information regarding ALL healthcare providers (for example, doctors, psychologists, therapists) who have treated you for the condition(s) listed in Section A. above:

a. _____

HEALTHCARE PROVIDER'S NAME	SPECIALTY
STREET OR BOX NUMBER	CITY/TOWN STATE ZIP CODE
TELEPHONE NUMBER	DATE YOU FIRST SAW THIS PROVIDER DATE YOU LAST SAW THIS PROVIDER

CONDITION(S) FOR WHICH YOU WERE TREATED BY THIS HEALTHCARE PROVIDER _____

Has this healthcare provider told you to cut back or limit your activities, as they relate to employment, in any way?

Yes No If "Yes," please explain what he or she told you about cutting back or limiting your activities:

(This section continued on next page)

B. ABOUT YOUR MEDICAL RECORDS (Continued)

b. _____
HEALTHCARE PROVIDER'S NAME _____ SPECIALTY _____

STREET OR BOX NUMBER _____ CITY/TOWN _____ STATE _____ ZIP CODE _____

TELEPHONE NUMBER _____ DATE YOU FIRST SAW THIS PROVIDER _____ DATE YOU LAST SAW THIS PROVIDER _____

CONDITION(S) FOR WHICH YOU WERE TREATED BY THIS HEALTHCARE PROVIDER _____

Has this healthcare provider told you to cut back or limit your activities, as they relate to employment, in any way?
 Yes No If "Yes," please explain what he or she told you about cutting back or limiting your activities:

c. _____
HEALTHCARE PROVIDER'S NAME _____ SPECIALTY _____

STREET OR BOX NUMBER _____ CITY/TOWN _____ STATE _____ ZIP CODE _____

TELEPHONE NUMBER _____ DATE YOU FIRST SAW THIS PROVIDER _____ DATE YOU LAST SAW THIS PROVIDER _____

CONDITION(S) FOR WHICH YOU WERE TREATED BY THIS HEALTHCARE PROVIDER _____

Has this healthcare provider told you to cut back or limit your activities, as they relate to employment, in any way?
 Yes No If "Yes," please explain what he or she told you about cutting back or limiting your activities:

(If you need more space, please use separate sheets of paper and clearly identify each question by number.)

2. Please furnish the following information regarding ALL hospitals or clinics where you have been treated for the condition(s) listed in Section A:

a. _____
INSTITUTION'S NAME _____

STREET OR BOX NUMBER _____ CITY/TOWN _____ STATE _____ ZIP CODE _____

TELEPHONE NUMBER _____ DATE YOU WERE FIRST TREATED HERE _____ DATE YOU WERE LAST TREATED HERE _____

CONDITION(S) FOR WHICH YOU WERE TREATED AT THIS INSTITUTION _____

b. _____
INSTITUTION'S NAME _____

STREET OR BOX NUMBER _____ CITY/TOWN _____ STATE _____ ZIP CODE _____

TELEPHONE NUMBER _____ DATE YOU WERE FIRST TREATED HERE _____ DATE YOU WERE LAST TREATED HERE _____

CONDITION(S) FOR WHICH YOU WERE TREATED AT THIS INSTITUTION _____

c. _____
INSTITUTION'S NAME _____

STREET OR BOX NUMBER _____ CITY/TOWN _____ STATE _____ ZIP CODE _____

TELEPHONE NUMBER _____ DATE YOU WERE FIRST TREATED HERE _____ DATE YOU WERE LAST TREATED HERE _____

CONDITION(S) FOR WHICH YOU WERE TREATED AT THIS INSTITUTION _____

B. ABOUT YOUR MEDICAL RECORDS (Continued)

3. Have you been seen by other agencies for reasons related to the condition(s) listed in Section A.? Yes No
(Veterans Administration, Workers' Compensation, Vocational Rehabilitation, Welfare, etc.) If "Yes," show the following for each agency:

NAME OF AGENCY

ADDRESS OF AGENCY

YOUR CLAIM NUMBER

DATES OF VISITS

TYPE OF SERVICES RECEIVED

(If you need more space, please use separate sheets of paper and clearly identify each question by number.)

C. ABOUT YOUR EMPLOYMENT

1. What is your current or most recent employment position?

JOB CLASSIFICATION IF KNOWN

BEGINNING AND ENDING DATES OF JOB

EMPLOYER (ORGANIZATION) NAME

EMPLOYER'S TELEPHONE NUMBER

STREET OR BOX NUMBER

CITY/TOWN

STATE

ZIP CODE

NAME OF SUPERVISOR

2. In general, describe this job: _____

3. Are you still working? Yes No If "No," when was your last day on the job? _____

4. Are you receiving: Sick leave pay? Yes No

Vacation pay? Yes No

Workers' Compensation? Yes No
If "Yes," for what condition? _____

Social Security disability benefits? Yes No
If "Yes," for what condition? _____

5. Did you have an injury or accident on the job? If so, describe the circumstances and date of the injury or accident. _____

6. Have you filed a claim for Workers' Compensation for this injury or accident? Yes No

If "Yes," what was the result of your claim? _____

D. ABOUT YOUR ABILITY TO WORK

- 1. When did you first experience difficulty working? _____
- 2. What difficulty did you first experience? _____
- 3. When were you first unable to work? _____
- 4. Did you continue working after this? Yes No

If "Yes," what enabled you to keep working? _____

5. Describe how each condition interferes with your ability to work. With respect to each condition, (noted in Section A, "About Your Condition(s)") list the employment task(s) that that condition makes you no longer able to perform. With respect to each employment task, provide the date when you were no longer able to perform it.

a. Condition: _____
Task(s): _____

b. Condition: _____
Task(s): _____

c. Condition: _____
Task(s): _____

6. If you think it is impossible for you to work only because of some or all of your medical conditions in combination, list the conditions in combination and explain in detail how the combination of these conditions makes it impossible for you to work. Be as specific as possible. _____

7. Are you still working? Yes No Today's date: _____

E. ABOUT YOUR FUTURE ABILITY TO WORK

- 1. How long do you think you will be unable to work? _____
- 2. What is the basis of this opinion? _____

- 3. What have your healthcare providers told you about your chances for improvement? Please identify each provider. _____

F. ABOUT YOUR EDUCATION, TRAINING AND EXPERIENCE

1. What is the highest grade of school that you completed? _____

2. Have you gone to college, trade, or vocational school or had any other type of special training? Yes No

If "Yes," show:

- The type of college, trade, vocational school, or training (include any degrees or certificates obtained):

- Approximate dates you attended:

- How this schooling or training was used in any work you did:

3. List the jobs you have had in the last 15 years before you stopped working or before your current job. (Include current job, if any.)

JOB TITLE/DESCRIPTION <small>(Be sure to begin with your most recent position)</small>	EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER	DATES WORKED (Month and Year)		HOURS PER WEEK	RATE OF PAY <small>(Per hour, day, week, month or year)</small>
		From	To		
1.					
2.					
3.					
4.					
5.					

F. ABOUT YOUR EDUCATION, TRAINING AND EXPERIENCE (Continued)

4. Please detail your experience with the following in any of your previous jobs:

- Use of machines, tools or equipment of any kind? _____

- Use of technical knowledge or skills? _____

- Writing, completing reports or performing similar duties? _____

- Supervisory or management responsibilities? _____

G. ABOUT YOUR ACTIVITIES

Describe your daily activities in the following areas and state what and how much you do of each and how often you do it.

- Household maintenance:
- Recreational activities and hobbies:
- Social contacts:
- Other:

I hereby authorize any company, 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 release 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 healthcare providers identified above may constitute the sole basis for determining my eligibility for a change in the normal beginning/ending date of my survivor benefits. MainePERS may, at its discretion and at its expense, request further medical examination(s) prior to making a final determination.

SIGN HERE  _____
APPLICANT

DATE HERE  _____

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

SIGNATURE	YOUR NAME (PRINT OR TYPE)	RELATIONSHIP
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Please explain why you are filling out this form for the applicant: _____

If you believe that you have authority to sign this form on behalf of the applicant, please state the basis for your authority. If the basis of your authority is set forth in a document(s), such as a power of attorney or appointment of guardianship, please attach copies of all relevant documentation.