Outside Earned Income Reporting For Short-Term Disability

Note: It is a program requirement that you complete this form if you have wages or salary from another job earned while receiving short-term disability benefits. The information requested on this form should only refer to employment other than your pre-disability job or a return-to-work program with the state.

Please complete this form and return it to your agency benefit's administrator within 30 days of beginning, or if continuing, any other employment.

Name: NameFull

Social Security #:

Onset of Injury/Illness:

1. Are you currently employed? Yes ☐ No ☐
2. Are you currently self-employed? Yes ☐ No ☐

NON-VRS Employer:

Name of your business, if self-employed:

Position:

Dates you held this position:

Hours worked per day:

Hours worked per week:

Number of days worked per week:

Earnings (salary or wages per hour):

Please describe your **JOB DUTIES AND RESPONSIBILITIES** below (or attach a separate sheet):

Please describe the **PHYSICAL DEMANDS OF YOUR JOB**:

Average amount of time during workday you:

Walk: Drive: Sit: Stand:

Average amount of weight you lift during a workday:

Frequently (34-66%) ☐ Occasionally (1-33%) ☐

Please describe ANY OTHER PHYSICAL DEMANDS of you job below:

I certify that this information is true to the best of my knowledge. Any overpayment of benefits (including those resulting from my failure to notify the earned income from a job other than my pre-disability job or a return to work program with the state) must be reimbursed with interest immediately and if not reimbursed immediately, could result in suspension of benefits and/or payroll docking to recover these funds. By signing this form, I give permission to recover any overpayment from my future VRS retirement benefits or from any VRS group life insurance proceeds that may be payable as a result of my death, or from any refund of my VRS member contribution account to secure repayment of any benefit overpayments. I understand it is my responsibility to notify my employer in writing within thirty (30) days of beginning or continuation of any outside employment (other than my pre-disability job or a state position coordinated through a return to work or temporary alternate duty program) or self-employment. I further agree to notify my employer of any change in disability status and failure to do so may result in suspension or termination of my benefits. I understand that any payment made to me that is later determined to have been procured on the basis of any false statement or falsification of any record knowingly made by me or on my behalf, or my failure to make any required report of change in disability or earning status, may be recovered by legal action.

Employee Name: _____

Employee Signature: _____

Date: _____

Please return this completed form to your pre-disability employer.