Worker's Compensation Carrier Certification Form

888 CalPERS (or **888**-225-7377) • TTY for Speech & Hearing Impaired: (877) 249-7442 Fax: (800) 959-6545

Member Name | CalPERS ID

This form is to be completed by the worker's compensation carrier that provides temporary disability benefits. If the member had more than one temporary disability leave period, a separate certification form must be completed for each leave period.

Workers Compensation Carrier Information:

Name of Employer's Disability Carrier

Carriers Address

Employee's Claim Number | Beginning Date of Temporary Disability Payments (mm/dd/yyyy) | Ending Date of Payments (mm/dd/yyyy)

Effective Date of Permanent Disability Rating (mm/dd/yyyy)

Was there a settlement by Compromise and Release? ☐ No ☐ Yes (If yes, you must provide a copy to CalPERS)

Signature of Authorized Worker's Compensation Carrier Representative: I hereby certify that the above information is true and correct. I understand this form provides CalPERS with the information required to determine eligibility and calculate the applicable service credit cost(s).

Carrier Representative Signature | Title | Date (mm/dd/yyyy)

Printed Name | Daytime Phone | Email | Fax