State of California
California Public Employees' Retirement System
www.calpers.ca.gov

Worker's Compensation Carrier Certification Form

Member Name (First Name, Middle Initial, Last 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 Center

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 provided 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 **Date (mm/dd/yyyy)**

Printed Name **Title**

Email **Daytime Phone** **Fax**