Reset Print

Office No.:

Laborers' and Retirement Board Employees' Annuity and Benefit Fund of Chicago

# DISABILITY WARRANT

**Instructions:** 1. Complete all "required" fields. Required fields are outlined with a **RED** Box.
2. Print the form.
3. Sign and Date the form.
4. Return the form to the LABF via mail or fax. (Mailing address and fax no. are printed below.)

| | | |
|---|---|---|
| Name: | | ☐ **Check here ONLY if your mailing address has changed** |
| Street Address: | | |
| Apt. #: | | |
| City, State, Zip: | | |
| Primary Phone No: | | ☐ **Check here ONLY if your phone no. has changed** |
| Secondary Phone No: | | |
| Email Address: | | ☐ **Check here ONLY if your email address has changed** |

**Payment Period:** MONTH / YEAR

**Type of Disability Benefit:**

**FORMS MUST BE RECEIVED AFTER THE 20TH OF THE MONTH TO ISSUE YOUR NEXT PAYMENT.**

- **Forms received prior to the 20th will be rejected.**
- **If you have returned to work, please complete and mail this form immediately.**

Please complete one of the following:

☐ I have not been released by the physician to return to work. I have earned additional outside monthly income in the amount of: $ _____. ☐ I have not earned additional income.

☐ I will return or have returned to work on this date: _____.

☐ I have been terminated as a City or Board Employee on this date: _____.

☐ I have resigned as a City or Board Employee on this date: _____.

**Please note: Employment changes not reported to the LABF will affect your future disability, refund or pension payments.**

**Additionally, under Illinois law (Public Act 97-0651) any person who knowingly makes any false statement or falsifies or permits to be falsified any record in an attempt to defraud the LABF is guilty of a Class 3 Felony.**

Signature: _____ Date: ____/____/____