TRISTAR
RISK MANAGEMENT

EXTENDED BENEFITS REQUEST

Injured Employee's Name _____ Social Security Number _____

Claim Number _____ Agency _____

Date of Injury _____

I request to be placed on extended benefits, effective _____, due to injuries received as a result of violence. Attached is a physician's statement describing the nature and extent of my disability, treatment and estimated return to work date.

I understand that I will receive my regular salary and benefits as long as I am unable to perform any work for up to a maximum of one year, without deductions from my accrued benefits. While receiving these benefits, I am not entitled to receive any salary compensation which would otherwise be due because of this injury from workers' compensation, the State Employees Retirement System of Illinois or any other insurance carried by the agency. Medical bills for examination and treatment will be processed through TRISTAR Risk Management.

I further state that I am not employed by any other employer in which I receive monetary or non-monetary payment for my services. In addition, I further state that I am not serving as a volunteer with any association, organization or employer, and I understand that I cannot perform volunteer work while collecting extended benefits. I also understand that if I have requested extended benefits and I am currently employed or if I accept other employment while receiving extended benefits that the extended benefits will be terminated and disciplinary action up to and including discharge will occur.

Finally, I understand that should I be found to have received duplicate benefits, those records will be forwarded to the appropriate state's attorney for prosecution.

_____ _____

Employee's Signature Date

AGENCY USE ONLY

DESCRIPTION OF INJURY: _____

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