North Carolina
Retirement Systems

# Form 703
## Reporting Earnings and Medical Report for Eligibility Review

Print or type in black ink. No erasures, strikeovers or whiteouts permitted. Do not staple pages.

**Section A. Tell us about yourself.**

| First Name | M.I. | Last Name | | Suffix |
|---|---|---|---|---|
| Mailing Address | | | Date of Birth | SSN |
| City | State | Zip Code | Phone (At least one phone required) | Mobile (At least one phone required) |
| Position Title | | | Today's Date | Member ID |

**Section B. Submit this form on the 1st business day of each calendar month.**

During the waiting period, and during the short-term period while you are receiving short-term disability benefits, you must report any earnings to your employer. The report (this form) is due on the 1st of every calendar month, and it should state earnings **received** during the previous calendar month. This form is required because the amount of your benefit may be affected by the amount of your earnings.

- The earnings you must report on this form include all compensation for work performed by you, including salaries, wages, fees, commissions, and net profits from self- employment.
- You should not report public assistance, child support, rental income, or income from investments.
- You do not need to report your short-term benefit or any private disability insurance.
- You do not need to report income from your employer that administers your short-term benefit. It is your employer's responsibility to report that income and add it to any income you report to make benefit calculations.
- If you are working for a second Teachers' and State Employees' Retirement System employer that is not administering your benefit, you need to report that income.

**You must submit this form to your employer even if you had no earnings.** After your employer has received the first page of this form from you, your employer will complete Section H on page 3 of this form and authorize payment from the employer's payroll if a benefit is due.

**Section C. Tell us about any earnings you received during the past month.**

| 1. | **This form represents a report of earnings received during the month of (MM-YYYY)** | |
|---|---|---|
| | Month | Year |

**2. Did you receive any compensation during this month?**

- If **YES**, complete the information about your earnings below. Attach copies of pay stubs or earning statements signed by your employer.

☐ Yes ☐ No

| Source of Income or Employer | Gross Amount Received | Date Received |
|---|---|---|
| | | |
| | | |
| | | |

**Continue to the next page.**

**N.C. Department of State Treasurer, Retirement Systems Division**
**3200 Atlantic Avenue, Raleigh, North Carolina 27604**
**NC.Retirement@nctreasurer.com • (919) 814-4590**

## Section C. Tell us about any earnings you received during the past month. (Continued)

| | |
|---|---|
| 3. | **Have you been approved for preliminary long-term benefits?**<br>• If **YES**, you do not need to complete the remainder of this form.<br>• If **NO**, please have your employer complete Section H of this form. You must give this form to your certified medical professional (physician, physician's assistant, family nurse practitioner, psychiatrist, psychologist, or chiropractor) to complete at the time of disability and every 30 days thereafter.<br>☐ Yes ☐ No |

I certify that all answers are true and correct to the best of my knowledge, and I understand that any misstatement is unlawful and may disqualify me from receiving benefits under the Disability Income Plan of North Carolina.

Member's Signature _____ Date _____

## Section D. Sign below to authorize the release of your medical reports.

I hereby authorize the undersigned medical professional to release any information acquired in the course of my examination or treatment to my employer as indicated below or to the NC Retirement Systems. I understand that this information is to be furnished at no cost to my employer or to the NC Retirement Systems.

Signature of Patient/Applicant _____ Date _____

## Section E. Medical Professional, tell us about your practice.

**Note:** Do not send a bill to the retirement system. The Retirement System will not assume any responsibility for payment of fees for furnishing the requested information.

| | | | | |
|---|---|---|---|---|
| Name of Practice/Facility | | Position Title | | |
| Physician's First Name | M.I. | Physician's Last Name | | |
| Mailing Address | | License Number | | |
| City | | State | Zip Code | Phone |

## Section F. Describe the disabling illness. For Medical Professional Use Only.

**Medical Professional:** As the patient's advocate, please describe the patient's illness(es) or condition(s) that may qualify the applicant for disability benefits and substantiate this information so that the patient's eligibility for benefits can be determined.

| | |
|---|---|
| 1. | **What is the principal cause of the disability?** |

| | |
|---|---|
| 2. | **How does the disability impact the patient's normal work activity? List any other restrictions or limitations to the patient's activities.** |

| | | | |
|---|---|---|---|
| 3. | **Please indicate the diagnosis(es) and whether each is causing or contributing to the disability.** | | |
| | **Diagnosis (Full Name Required)** | **Causing or Contributing** | **Code (Optional)** |
| | | | |
| | | | |

**Continue to the next page.**

## Section F. Describe the disabling illness. For Medical Professional Use Only. (Continued)

| 4. | What date did the patient become unable to work, that is, disabled (mm-dd-yyyy)? | | |
|---|---|---|---|
| | Month | Day | Year |

| 5. | What is the expected duration of the member's disability, from the date of the Physician's signature below?<br>*- This is an estimated time frame in which the member is expected to be disabled.* |
|---|---|

## Section G. Medical Professional, certify your evaluation for the member's visit.

I hereby certify that the patient named in Section A of this form became disabled and unable to perform his/her regular job on the day given (Question 4) with the diagnosis(es) given (Question 3), and that he/she was continuously disabled to the extent that he/she could not perform his/her regular job through today's evaluation date below or the last day of the illness, whichever is first. **Note:** Stamps are not accepted.

Signature of Physician _____ Date _____

## Section H. Submit this form to the employer listed below after completing Sections E, F, & G.

| Contact First Name | | Contact Last Name | |
|---|---|---|---|
| Employer / Agency | | Contact Position Title | |
| Mailing Address | City | State | Zip Code |
| Email Address | | Phone | Fax |

| Member Last Name | SSN |
|---|---|

**Submit this form to your employer to receive short-term benefits.**