FR-13e
Rev. 07/06
Disability Determination

Florida Retirement System
Retiree's Report of Continuing Disability

PO BOX 9000 Tallahassee, FL 32315-9000
Local Phone: 850-907-6500 Toll Free: 844-377-1888 FAX: 850-410-2010

Please print or type:

Retiree Name _____ Retiree SSN _____

Address _____ Date _____

_____ Phone _____

_____

_____

A. Instructions: (Please read carefully before completing this form.)

Section 121.091(4)(h)1., Florida Statutes, provides for the periodic reevaluation of all individuals receiving disability benefits under the Florida Retirement System. You should complete this Disability Reevaluation Statement and have a physician who is now treating or who has treated your disabling conditions to complete the enclosed Form FR-13f. When complete, **both forms** should be sent to the Division of Retirement, at the above referenced address. Should the physician charge for completing Form FR-13f, a copy of the bill should be attached to the forms so that the Division of Retirement can issue **you** a warrant to pay for such charges.

Please furnish the Division with the requested information within sixty (60) days from the date you receive these forms. In the event you cannot furnish this information within sixty (60) days, notify the Disability Determination Section by writing or calling the Division of Retirement (see top of the page for Division contact information). **Unless you submit both forms or are granted an extension to the sixty (60) days, we will hold your retirement checks until the information is received.**

B. Medical Treatment subsequent to Disability Retirement:

1. Since the date of your disability retirement or the date you last completed a Disability Evaluation Statement:
   a. Have you received medical or therapeutic treatment of any kind? Yes _____ No_____
   b. Have you been under the regular care and supervision of a physician? Yes _____ No_____
   c. Have you been hospitalized? Yes _____ No_____

C. Employment Since Disability Retirement:

1. Since the date of your disability retirement, or the date you last completed a Disability Evaluation Statement, have you ever been employed in any capacity?

   Yes ____ No ____ **(If "Yes", please explain on next page.)**

FR-13e
Rev. 07/06
Disability Determination

Florida Retirement System
Retiree's Report of Continuing Disability

Retiree Name: _____ Retiree SSN: _____

Dates of Employment: _____ Employer: _____

Position Held: _____

Reasons for Terminating: _____

2. Have you ever received disability benefits from Social Security, Workers' Compensation, Veterans' Administration, or any other public or private agency?

Yes ____ No ____ **(If "Yes", please list the source of those benefits received.)**

D. Present Condition:

1. Do you feel you are capable of engaging in any gainful employment? **Yes ____ No____ (If "No", please explain.)**

2. If you have any additional comments you wish to make concerning your present condition, please provide them in the following space. Should additional space be required, please attach a separate sheet.

I affirm that all information and statements provided on this form are true and correct to the best of my knowledge.

I hereby specifically authorize the release of any records which may exist concerning me, including but not limited to employment records with previous employers, records with other Retirement Systems, with Veterans' Administration, Social Security Administration, and any other records and reports which the Division deems necessary in their investigation of my application for retirement, and for which a personal release signed by me may be required.

_____ _____
Member Date