

## **Permanent Disability or Chronically Ill Certification—Information and Instructions**

---

### **INFORMATION**

This *Permanent Disability or Chronically Ill Certification* form should be completed by the Eligible Designated Beneficiary and the Eligible Designated Beneficiary's physician to certify the Eligible Designated Beneficiary is permanently disabled or chronically ill in order to receive Required Minimum Distributions (RMDs) over their life expectancy.

If your physician certifies via this form that you are permanently disabled or chronically ill, you may request to receive RMDs over your life expectancy and you will not be required to deplete the account by December 31 of the 10th year following the primary participant's death<sup>1</sup>.

This form may not be altered in any way or substituted with any other form of disability or chronically ill certification. Any such alteration or substitution is considered invalid.

### **INSTRUCTIONS**

**Part 1** – Enter your personal information. Use a black pen and print clearly in CAPITAL LETTERS.

**Part 2** – Ask your physician to complete this section of the form.

Send the completed form to Wespath via e-mail, fax or mail. Be sure to keep a copy for your records.

Contact Wespath to request an application for benefits to start your distribution.

---

<sup>1</sup> The life expectancy election must be made by December 31<sup>st</sup> of the year following the year of the primary participant's death. For administration purposes, please submit this form no later than October 15<sup>th</sup> of the year following the year of the primary participant's death.



## Permanent Disability or Chronically Ill Certification

---

### Part 1 – Personal Information

Name \_\_\_\_\_ Social Security # (last 5 digits) \_\_\_\_\_  
 Address \_\_\_\_\_ Primary phone # \_\_\_\_\_  
 \_\_\_\_\_ Employer \_\_\_\_\_

---

### Part 2 – Physician Certification of Permanent Disability (to be completed by physician)

I hereby certify that in my medical opinion (*print patient's name*) \_\_\_\_\_  
 as of (*effective date*) \_\_\_\_\_ is found to be permanently disabled and is unable to engage in any  
 substantial gainful activity by reason of any medically determinable physical or mental impairment, which can be expected  
 to result in death or to be of long-continued and indefinite duration.

I further certify that I am a physician licensed to practice medicine in one or more states of the United States of America  
 and that I have examined the foregoing patient in the course of forming my opinion.

Physician name (*printed*) \_\_\_\_\_ Degree \_\_\_\_\_  
 State of jurisdiction of medical license \_\_\_\_\_ Specialty \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

---

### Part 3 – Physician Certification of Chronically Ill (to be completed by physician)

I hereby certify that in my medical opinion (*print patient's name*) \_\_\_\_\_  
 as of (*insert date of plan participant's death*) \_\_\_\_\_ is chronically ill. A chronically ill individual  
 is someone who has been certified by a licensed health care practitioner as (1) being unable to perform, without substantial  
 assistance from another individual, at least two daily living activities (eating, toileting, transferring, bathing, dressing, and  
 continence) due to a loss of functional capacity, and whose condition is reasonably expected to be indefinite, and lengthy  
 in nature; or (2) requiring substantial supervision to protect the individual from threats to health and safety due to severe  
 cognitive impairment.

I further certify that I am a physician licensed to practice medicine in one or more states of the United States of America  
 and that I have examined the foregoing patient in the course of forming my opinion.

Physician name (*printed*) \_\_\_\_\_ Degree \_\_\_\_\_  
 State of jurisdiction of medical license \_\_\_\_\_ Specialty \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

Please complete this form and send via:  
 email: [survivorteam@wespath.org](mailto:survivorteam@wespath.org); fax: 1-847-866-4677  
 or mail to:  
 Wespath Benefits and Investments  
 Survivor Benefits  
 1901 Chestnut Ave.  
 Glenview, IL 60025-1604