KENTUCKY PUBLIC PENSIONS AUTHORITY
1260 Louisville Road • Frankfort, KY 40601
Phone: (502) 696-8800 • Fax: (502) 696-8822 • kyret.ky.gov

Print Form

Form 8102
Revised 04/2024

EMPLOYMENT AND MEDICAL STAFF REVIEW CERTIFICATION REINSTATEMENT

Member Information Please provide your Member ID or Social Security number in the Member ID box below.

Member Name:		Member ID:	
KPPA will update contact information for your retirement account based on the details provided below.			
Address:	City:	State:	Zip Code:
Phone (select type) ☐ Mobile ☐ Home ☐ Work		Email:	

Employment Status (You must choose one):

☐ **Yes**, I have been employed (including work in any capacity that is, or may be, performed with regularity and is, or may be, usually done for pay, whether or not pay is received, including seasonal, volunteer, part-time, and on-call work) since the date I was approved for disability retirement benefits or since my last employment and medical staff review. Must also complete and file Form 8130, Disability Retiree Employment Reporting.

☐ **No**, I have not been employed (including work in any capacity that is, or may be, performed with regularity and is, or may be,usually done for pay, whether or not pay is received, including seasonal, volunteer, part-time, and on-call work) since the date I was approved for disability retirement benefits or since my last employment and medical staff review.

☐ **No**, I have not been employed (including work in any capacity that is, or may be, performed with regularity and is, or may be, usually done for pay, whether or not pay is received, including seasonal, volunteer, part-time, and on-call work) since the date I was approved for disability retirement benefits or since my last employment and medical staff review, but I have enclosed a Form 8130, Disability Retiree Employment Reporting, for a position I would like to be reviewed for potential future employment.

Certification of Medical and Employment Information

I, _____, hereby certify that the employment information provided on this form and the attached medical information are true, correct, accurate, and complete, meaning the attached information consists of **all** the existing medical information regarding the bodily injury, mental illness, or disease for which I was approved for disability retirement benefits since my last employment and medical staff review or since my benefits were terminated. I further certify that this form and the attached medical information are complete and ready to be reviewed by the medical staff.

I am aware that I am eligible to apply for the reinstatement of my disability benefits pursuant to KRS 61.615 and 78.5528, and that I am responsible for filing supporting medical information to report my current physical and mental condition pursuant to KRS 61.610 and 78.5526. I am also aware that by signing this certification I am certifying to Kentucky Public Pensions Authority that the enclosed medical records represent all the evaluations, examinations, and treatment I have had for the bodily injury, mental illness, or disease for which I was approved for disability retirement benefits, including all reports of diagnostic medical testing performed on me. Written statements from medical providers alone are not medical information unless accompanied by supporting records as discussed in this paragraph.

I am aware that if I have been employed (including work in any capacity that is, or may be, performed with regularity and is, or may be, usually done for pay, whether or not pay is received, including seasonal, volunteer, part-time, and on-call work) since the date I was approved for disability retirement benefits or since my last employment and medical staff review, I must also attach a Form 8130, Disability Retiree Employment Reporting, even if the position has been previously approved by Kentucky Public Pensions Authority.

I acknowledge that I have full understanding that any person who provides a false statement, report, or representation to a governmental entity such as KPPA is subject to the penalty of perjury in accordance with KRS 523.010, et seq. I further acknowledge that if I knowingly submit or cause to be submitted a false or fraudulent claim for the payment or receipt of benefit, I may be liable for repayment of benefits I was not entitled to receive, but also liable for civil payments, legal fees, and costs.

Signature: _____ Date: _____

Printed Name: _____