



# DISABILITY RETIREE EMPLOYMENT REPORTING



**Form 8130**  
Revised 04/2024

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

Member Name:	Member ID:
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KPPA will update contact information for your retirement account based on the details provided below.

Address:	City:	State:	Zip Code:
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Date of Birth:	Phone (select type) <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work	Email:
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**Position Description**

**A detailed position description must be included with this form in order for the form to be considered complete. The job description attached must be provided to you by the employer, and at a minimum must include:**

- the name of the employing company/organization,
- a list of required job duties, and
- the number of hours that will be worked per week.

**Position Information**

**If you have not yet started in the position, complete the form with as much detail as possible about what you anticipate the job duties will be. Attach additional pages if necessary.**

Mark your employment status as of the date this form is signed:  Working  Hired, not yet working  Potential future hire

Employer Name:	Job Title:
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Employer Address:

Employer Phone:	Employer Contact Person:
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Start Date:	Hours per day:	Hours per week:
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Percentage of hours sitting per work day:  up to 25%  25% - 50%  50% - 75%  75% - 100%

Percentage of hours standing/walking per work day:  up to 25%  25% - 50%  50% - 75%  75% - 100%

In this position, are you able to alternate between sitting and standing/walking as needed?  Yes  No

Description of job duties:  
\_\_\_\_\_  
\_\_\_\_\_

What specific physical effort (lift, carry, push, pull, stoop, reach, climb, balance, etc.) is required to perform the job duties:  
\_\_\_\_\_  
\_\_\_\_\_

What specific mental effort (make decisions, maintain concentration, adapt to changes, handle stress, understand, remember and carry out instructions, etc.) is required to perform the job duties:  
\_\_\_\_\_  
\_\_\_\_\_

Are you receiving accommodations (modified work schedule, assistive equipment, restructuring, special allowances, etc.), assistance, or help to perform the essential job duties?  Yes  No **If YES, describe:**  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Certification**

I certify that all the information completed on this form is true and accurate. 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.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_