KP&F-560
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Kansas Public Employees Retirement System
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Employer's Report of a Death, Disability or On-The-Job Accident

Please type or print using black ink.

Part A – General Information

1. Member's Social Security Number: ____________-_______-______________

2. Member's Name (Please Print): ______________________________

3. Address: ______________________________

4. Last Day on Payroll (Mo/Day/Yr): ______________ 5. Last Day Actively at Work (Mo/Day/Yr): ______________

Part B – On-the-Job Accident – Complete this section if not reported to Workers' Compensation.

If additional space is needed, please attach extra sheets.

1. Place of Accident: ______________________________

2. What was the employee doing when the accident occurred? ______________________________

3. Give the date and hour of the accident: ______/______/______, ______ a.m. ______ p.m.

4. How did the accident happen? ______________________________

5. Did the member receive treatment? ☐ Yes ☐ No
If yes, give date and name of practitioner and/or hospital/clinic: ______________________________

6. Has the member returned to employment? ☐ Yes ☐ No If yes, what date? ______/______/______

Part C – Disability from any Cause

1. Date disability commenced: ______/______/______

2. Describe disability: ______________________________

3. Was it due to an accident as a result of performance of duties as a police officer, firefighter, or emergency medical technician under employment? ☐ Yes ☐ No

4. Was it reported to Workers' Compensation? ☐ Yes ☐ No If yes, please attach a copy.

5. Did the member have other employment? ☐ Yes ☐ No

6. Was the disability incurred in the course of employment for compensation with another employer? ☐ Yes ☐ No
If yes, give name and address of employer: ______________________________

Part D – Death from any Cause

1. Date of Death: ______/______/______ 2. Cause of Death: ______________________________

3. Was the death service-connected as defined in K.S.A. 74-4952(10)? ☐ Yes ☐ No

4. Name and age of member's surviving spouse: ______________________________

5. Name and age of any dependent, minor children: ______________________________

Part E – Employer's Certification

Agency ID #: ______________ Name of Employer: ______________________________

Signature of Designated Agent: ______________________________ Date: ______________

Department of Administration Authorized Signature (State Agencies Only): ______________________________
(required for deaths only)