COMMONWEALTH OF PENNSYLVANIA
STATE EMPLOYEES' RETIREMENT SYSTEM
SERS CENTRAL COUNSELING - OUT OF STATE
30 N 3RD STREET
SUITE 150
HARRISBURG, PA 17101-1716
800 633 - 5461
www.sers.state.pa.us

Region

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SERS USE ONLY
DOR _____

◆ APPLICATION FOR DISABILITY RETIREMENT ◆ VESTED

PART 1 MEMBER INFORMATION

NAME FIRST	MIDDLE	LAST	DATE OF BIRTH (ATTACH DOCUMENTATION) MONTH DAY YEAR
STREET ADDRESS			SEX ☑ MALE ☐ FEMALE
CITY	STATE	ZIP CODE	LAST EMPLOYING AGENCY / DEPARTMENT:
PHONE:	DATE OF TERMINATION:		

PART 2 DISABILITY COUNSELING CHECKLIST

1	Provided explanation of creditable State service and non-State service (such as intervening and non-intervening military service) which may be purchased, the costs, and the increase in benefits derived from such purchase.	
2	Benefits derived from the election of multiple service with the Public School Employees' Retirement System.	
3	Benefit reduction in the event of a debt to the employer and/or a retirement arrears liability (actuarial debt) exists at the time of retirement.	
4	The effect on future retirement benefits should I return to active state/school service.	
5	Provided with explanation of disability options and death benefits; Maximum, as well as Option 2 and 3.	
6	Provided estimates for Maximum Disability Option.	
7	Under Maximum Disability you may change beneficiaries anytime by filing a new beneficiary nomination form.	
8	Provided estimates for Disability Options 2 and 3.	
9	Qualifying events under Options 2 or 3 which permit the change of option and/or survivor, including procedures and the effect to member's annuity. If the designated survivor predeceases the member the benefit is automatically considered Maximum retirement with no death benefits. No death benefits are available until a new option is elected.	
10	REHP/PEBTF retiree health insurance is not available when member is from a non SEHP participating agency. Directed member to their employer for additional information. (IF NOT REHP ELIGIBLE ENTER N/A IN ITEMS 11.,12., AND 13.	
11	Provided explanation of enrollment and eligibility requirements for Majority and $5.00 State Share REHP coverage, including requirements should their disability retirement be disapproved or discontinued. Under Majority State Share, the % Member Share Monthly Amount = _____ ☐ Accepts coverage with stated cost. ☐ Defers enrollment. May defer once, to a later date, due to coverage with another plan at this time.	
12	Member was provided with the Medicare Part B policy and advised that REHP also stops if the disability retirement is discontinued.	
13	Provided explanation of COBRA eligibility and benefits. Member and dependents (when covered) received a COBRA notice.	
14	Provided explanation of vesting rights and procedures should the member not apply for retirement or if the disability is denied.	
15	Provided an explanation of the requirement to report earned income to the State Employees' Retirement System until the member reaches their Normal Retirement Age, the amount of income which may be earned in addition to the disability benefit, and the effect of exceeding that limit. Also the requirement for the member to supply copies of Worker's Compensation and Social Security Disability award letters to SERS upon receipt.	
16	Provided an explanation of the appeal process should a disability retirement be denied or discontinued.	

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PART 2 (continued) RETIREMENT COUNSELING CHECKLIST

17	Provided estimates of all benefits available should the disability retirement be denied or discontinued.	
18	Provided explanation of the procedures to apply for Social Security benefits.	
19	Provided information on the taxability of disability retirement benefits and advised the member to seek qualified tax advice.	
20	Option to withdraw contributions from the optional SSI Program and the effect of such withdrawal.	

Member Initial

I HAVE BEEN COUNSELED TO MY SATISFACTION ON ALL ITEMS ON THIS CHECKLIST, EXCEPT THOSE MARKED "N/A". THE RETIREMENT COUNSELOR PROVIDED ESTIMATES AND EXPLANATIONS TO THE EXTENT THAT I AM FULLY AWARE OF ALL BENEFITS TO WHICH I AM ENTITLED. I HAVE ALSO BEEN PROVIDED WITH A COPY OF THE "MEMBER'S GUIDE TO DISABILITY RETIREMENT".

PART 3 VESTED DISABILITY

DISABILITY MAXIMUM SINGLE LIFE ANNUITY

I UNDERSTAND, IF APPROVED FOR DISABILITY RETIREMENT, UNDER THIS OPTION I WILL RECEIVE THE MAXIMUM DISABILITY BENEFIT AND A VALUE WILL BE PLACED ON MY RETIREMENT ACCOUNT CALLED THE ACCOUNT "PRESENT VALUE". ALL PAYMENTS ARE SUBTRACTED FROM THE PRESENT VALUE. ANY BALANCE REMAINING AT MY DEATH WILL BE PAID TO MY BENEFICIARY(IES). I MAY NAME ONE OR MORE BENEFICIARIES IN PART 5 OF THIS APPLICATION AND MAY CHANGE BENEFICIARY(IES) AT ANY TIME BY FILING A NEW RETIRED MEMBER BENEFICIARY NOMINATION FORM.

SIGNATURE:

DISABILITY OPTION 2

I UNDERSTAND, IF APPROVED FOR DISABILITY RETIREMENT, UNDER THIS OPTION I WILL RECEIVE A REDUCED DISABILITY BENEFIT THAT IS COMPOSED OF TWO PARTS: AN EARLY RETIREMENT PORTION AND THE DISABILITY SUPPLEMENT. THIS REDUCED DISABILITY BENEFIT WILL BE CALCULATED BASED ON THE AGE AND SEX OF MYSELF AND MY DESIGNATED SURVIVOR. UPON MY DEATH, THAT PERSON WILL RECEIVE, FOR LIFE, THE SAME MONTHLY AMOUNT THAT I WAS ELIGIBLE TO RECEIVE UNDER EARLY RETIREMENT AND ANY OUTSTANDING AMOUNTS PAYABLE TO ME AS OF THE DATE OF MY DEATH. I UNDERSTAND THAT MY DESIGNATED SURVIVOR MUST BE NAMED IN PART 6 OF THIS FORM.

SIGNATURE:

DISABILITY OPTION 3

I UNDERSTAND, IF APPROVED FOR DISABILITY RETIREMENT, UNDER THIS OPTION I WILL RECEIVE A REDUCED DISABILITY BENEFIT THAT IS COMPOSED OF TWO PARTS: AN EARLY RETIREMENT PORTION AND THE DISABILITY SUPPLEMENT. THIS REDUCED DISABILITY BENEFIT WILL BE CALCULATED BASED ON THE AGE AND SEX OF MYSELF AND MY DESIGNATED SURVIVOR. UPON MY DEATH, THAT PERSON WILL RECEIVE, FOR LIFE, ½ OF THE MONTHLY AMOUNT THAT I WAS ELIGIBLE TO RECEIVE UNDER EARLY RETIREMENT AND ANY OUTSTANDING AMOUNTS PAYABLE TO ME AS OF THE DATE OF MY DEATH. I UNDERSTAND THAT MY DESIGNATED SURVIVOR MUST BE NAMED IN PART 6 OF THIS FORM.

SIGNATURE:

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PART 4 FEDERAL INCOME TAX WITHHOLDING MONTHLY PAYMENTS W4-P

☐ Check here if you DO NOT WANT any Federal Income tax withheld from your monthly annuity payments.

☐ I would like Federal Income tax withheld as indicated below:

Number of Allowances	Marital Status	Optional - Additional Withholding - you must also enter the number of allowances and marital status
_____ 0 - 9	☐ Single ☐ Married	Additional amount to be withheld from each monthly payment. $ _____

NOTE: ALL NOMINATIONS OF A BENEFICIARY OR SURVIVOR IN PARTS 5-8 ON THIS APPLICATION FOR ANNUITY ONLY TAKE EFFECT WITH THE EFFECTIVE DATE OF YOUR RETIREMENT. TO UPDATE YOUR BENEFICIARY PRIOR TO YOUR DATE OF RETIREMENT YOU MUST COMPLETE A SERS-402 ACTIVE MEMBER BENEFICIARY NOMINATION FORM.

PART 5 RETIREMENT NOMINATION OF BENEFICIARY(IES) FOR MAXIMUM DISABILITY ONLY

PRINCIPAL BENEFICIARY(IES)

In the event of my death any remaining balance of my account shall be paid as designated below.

☐ Pay to one person, estate or trust

☐ Pay to more than one person, estate or trust in equal shares with rights to survivors

☐ Pay to more than one person absolutely

☐ Distribute in designated percentages as shown

Percent	Full Name	Birth Date	Address (street address, city, state, zip code)
	Total must equal 100%		

CONTINGENT BENEFICIARY(IES)

In the event of the death of all my principal beneficiaries, any remaining balance of my account shall be paid as designated below.

Percent	Full Name	Birth Date	Address (street address, city, state, zip code)
	Total must equal 100%		

PART 6 DESIGNATION OF A SURVIVOR ANNUITANT DISABILITY OPTIONS 2 OR 3 ONLY

Full Name	Date of Birth	Sex ☐ MALE ☐ FEMALE	Social Security Number

Address (street address, city, state, zip code)

Relationship ☐ SPOUSE ☐ OTHER

I understand that the beneficiary/survivor nomination(s) I made on this page will only become valid with the effective date of my annuity.

Signature:

Date:

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PART 7 TEMPORARY OPTION 2/3 CONTINGENT BENEFICIARY DISABILITY OPTIONS 2 OR 3 ONLY

This part should only be used by a member electing an Option 2 or Option 3 Disability Survivor plan. This contingent beneficiary nomination is invalid once your initial check is received.

*** NOTE - DO NOT complete this part of the form if you are electing a Maximum Disability.**

I understand that if I die before I receive my initial annuity payment from the Retirement System, any outstanding amount will be paid to my designated survivor.

Further, **I also understand and declare that,** if both myself and my designated survivor die before my initial annuity payment is received, I wish to have any payments due me to be paid to the following contingent beneficiary(ies):

NAME	DATE OF BIRTH	ADDRESS (street address, city, state, zip code)

PART 8 GUARDIAN

REQUIRED FOR ANY BENEFICIARY OR DESIGNATED SURVIVOR UNDER 18 YEARS OF AGE NAMED IN PARTS 5, 6 OR 7 OF THIS APPLICATION

Full Name	Address (street address, city, state, zip code)	Name of Minor(s)

PART 9 CREDITED NON-STATE SERVICE DECLARATION

This part must be completed if the member is claiming credits for "creditable non-state service".
Failure to complete this part of the application for annuity shall result in the cancellation and forfeiture of any non-state service previously credited to the member's account.

STATE EMPLOYEES' RETIREMENT CODE - §5304 (CREDITABLE NONSTATE SERVICE) provides, in part:

"(b) An active member or multiple service member who is a school employee and an active member of the Public School Employees' Retirement System shall be eligible to receive credit for non-state service provided that he does not have credit for such service under a retirement system administered and wholly or partially paid for by any other governmental agency or by any private employer, or a retirement program approved by the employer..."

Member Initial

I HAVE READ AND UNDERSTAND THE ABOVE SECTION OF THE STATE EMPLOYEES' RETIREMENT CODE, AND I CERTIFY THAT I HAVE NOT ALREADY RECEIVED, AM NOT NOW RECEIVING, NOR WILL I BE ELIGIBLE TO RECEIVE IN THE FUTURE, ANY RETIREMENT BENEFITS UNDER A RETIREMENT SYSTEM ADMINISTERED BY ANY OTHER GOVERNMENTAL AGENCY FOR ANY NONSTATE SERVICE WHICH IS CREDITED TO MY ACCOUNT IN THE STATE EMPLOYEES' RETIREMENT SYSTEM, WITH THE EXCEPTION OF THE MILITARY PENSION SYSTEMS UNDER TITLE 10, CHAPTER 67, UNITED STATES CODE, SECTIONS 1331-1337.

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PART 10 MEMBER CERTIFICATION

STATE EMPLOYEES' RETIREMENT CODE

§5954 (FRAUD AND ADJUSTMENT OF ERRORS) provides, in part

"(a) Any person who shall knowingly make any false statement or shall falsify or permit to be falsified any record or records of this system in any attempt to defraud the system as a result of such act shall be guilty of a misdemeanor of the second degree."

§5907 (RIGHTS AND DUTIES OF STATE EMPLOYEES AND MEMBERS) provides, in part:

"(a) ... In any case in which the board finds that a member is receiving an annuity based on false information, the total amount received predicated on such false information together with statutory interest doubled and compounded shall be deducted from the present value of any remaining benefits to which the member is legally entitled."

I, _____, HEREBY MAKE THE FOLLOWING CERTIFICATION: HAVING READ AND
(Signature)
UNDERSTOOD ALL OF THE PRECEDING PROVISIONS, CERTIFYING THAT ALL STATEMENTS MADE ON THIS APPLICATION ARE TRUE AND CORRECT, I UNDERSTAND THAT THE DISABILITY RETIREMENT OPTION PLAN ELECTIONS I MADE ON THIS APPLICATION ARE FINAL AND BINDING. I ALSO UNDERSTAND THAT I MAY BE REQUIRED TO REPORT EARNINGS ON A CONTINUING BASIS AND TO PROVIDE MEDICAL EVIDENCE OF DISABILITY TO THE STATE EMPLOYEES' RETIREMENT SYSTEM AS REQUIRED. I THEREFORE AUTHORIZE AND PERMIT THE STATE EMPLOYEES' RETIREMENT SYSTEM TO MAKE DIRECT CONTACT WITH ANY OR ALL DOCTORS WHO MAY HAVE SUBMITTED MEDICAL REPORTS ON MY BEHALF. I ALSO UNDERSTAND THAT ANY WILLFUL FALSIFICATION OR FAILURE TO PROVIDE THE INFORMATION REQUIRED MAY RESULT IN THE FORFEITURE OF MY RIGHTS TO FUTURE BENEFITS BASED ON SUCH INFORMATION AND SUCH OTHER PENALTIES AS PROVIDED BY LAW, AND I HEREBY DECLARE THAT I INTEND TO BE LEGALLY BOUND BY THIS STATEMENT AND THESE RETIREMENT ELECTIONS.

DATE: ___/___/___

YOUR SIGNATURE MUST BE WITNESSED BY TWO PERSONS.

WITNESS SIGNATURE:	**WITNESS SIGNATURE:**
ADDRESS	**ADDRESS**

COUNSELING NOTES: