



Region 8

SS#
SERS USE ONLY
DOR _____

◆ **APPLICATION FOR DISABILITY RETIREMENT** ◆
NON-VESTED

PART 1				MEMBER INFORMATION		
NAME	FIRST	MIDDLE	LAST	DATE OF BIRTH (ATTACH DOCUMENTATION)		
				MONTH	DAY	YEAR
STREET ADDRESS				SEX	<input type="checkbox"/> MALE	<input type="checkbox"/> 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 under Maximum disability.	
6	Provided estimates for Maximum Disability Option.	
7	Under Maximum Disability, when a death benefit remains, I may change beneficiaries by filing a new beneficiary form.	
8	REHP/PEBTF retiree health insurance is not available when member is from a non AEHP participating agency. Directed member to their employer for additional information. (IF NOT REHP ELIGIBLE ENTER N/A IN ITEMS 9 THROUGH 12)	
9	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 = _____ <input type="checkbox"/> Accepts coverage with stated cost. <input type="checkbox"/> Defers enrollment. May defer once, to a later date, due to coverage with another plan at this time.	
10	REHP coverage will not begin until ANY & ALL outstanding AEHP financial obligations are settled directly with PEBTF.	
11	Member is subject to the rules of Least Expensive Plan (LEP). Buy-up fee is applied if member chooses PPO plan.	
12	Member was provided with the Medicare Part B policy and advised that REHP also stops if the disability 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.	
16	Provided an explanation of the appeal process should a disability retirement be denied or discontinued.	
17	Provided explanation of the loss of monthly retirement and health insurance benefits should the disability retirement be denied or discontinued. Also the requirement for the member to supply copies of Worker's Compensation and Social Security Disability award letters to SERS upon receipt.	
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.	

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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".

Member Initial

PART 3 NON-VESTED DISABILITY

I UNDERSTAND THAT, IF APPROVED BY THE STATE EMPLOYEES' RETIREMENT SYSTEM, I WILL RECEIVE A DISABILITY RETIREMENT BENEFIT. UPON MY DEATH, MY BENEFICIARY(IES) WILL RECEIVE MY ACCUMULATED DEDUCTIONS (THE VALUE AS OF THE DATE OF RETIREMENT) MINUS ONE THIRD (1/3) OF THE TOTAL PAYMENTS I RECEIVED. I MAY NAME ONE OR MORE BENEFICIARIES IN PART 5 OF THIS APPLICATION AND WHEN A DEATH BENEFIT REMAINS, I MAY CHANGE BENEFICIARIES BY COMPLETING A NEW RETIRED MEMBER BENEFICIARY NOMINATION FORM.

SIGNATURE:

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	<input type="checkbox"/> Single <input type="checkbox"/> Married	Additional amount to be withheld from each monthly payment. \$ _____

NOTE: ALL NOMINATIONS OF A BENEFICIARY IN PARTS 5-6 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) 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 absolutely
- Pay to more than one person, estate or trust in equal shares with rights to survivors
- 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%			

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

Signature:

Date:

SS#

PART 6 GUARDIAN
REQUIRED FOR ANY BENEFICIARY UNDER 18 YEARS OF AGE NAMED IN PART 5 OF THIS APPLICATION

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

PART 7 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.

PART 8

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. I UNDERSTAND THAT SERS IS A COMMONWEALTH AGENCY SUBJECT TO THE PENNSYLVANIA RIGHT-TO-KNOW LAW (RTKL). IN RESPONSE TO RTKL REQUESTS, SERS MAY BE REQUIRED TO DISCLOSE CERTAIN RECORDS RELATED TO MY RETIREMENT BENEFIT, INCLUDING BUT NOT LIMITED TO MY NAME AND RETIREMENT BENEFIT OPTION AND AMOUNT AND HOME ADDRESS.

DATE: ____ / ____ / ____

YOUR SIGNATURE MUST BE WITNESSED BY TWO PERSONS.

WITNESS SIGNATURE:

WITNESS SIGNATURE:

ADDRESS

ADDRESS

COUNSELING NOTES: