



**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 99

SS#

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 <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; 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 AEHP participating agency. Directed member to their employer for additional information. (IF NOT REHP ELIGIBLE ENTER N/A IN ITEMS 11 THROUGH 14)	
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 = _____ <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.	
12	REHP coverage will not begin until ANY & ALL outstanding AEHP financial obligations are settled directly with PEBTF.	
13	Member is subject to the rules of Least Expensive Plan (LEP). Buy-up fee is applied if member chooses PPO plan.	
14	Member was provided with the Medicare Part B policy and advised that REHP also stops if the disability retirement is discontinued.	
15	Provided explanation of COBRA eligibility and benefits. Member and dependents (when covered) received a COBRA notice.	
16	Provided explanation of vesting rights and procedures should the member not apply for retirement or if the disability is denied.	
17	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.	
18	Provided an explanation of the appeal process should a disability retirement be denied or discontinued.	

PART 2 (continued) RETIREMENT COUNSELING CHECKLIST

19	Provided estimates of all benefits available should the disability retirement be denied or discontinued.	
20	Provided explanation of the procedures to apply for Social Security benefits.	
21	Provided information on the taxability of disability retirement benefits and advised the member to seek qualified tax advice.	
22	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, 1/2 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:

SS#

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

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 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."

<p>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.</p>	
DATE: ____ / ____ / ____	
YOUR SIGNATURE MUST BE WITNESSED BY TWO PERSONS.	
WITNESS SIGNATURE:	WITNESS SIGNATURE:
ADDRESS	ADDRESS
COUNSELING NOTES:	